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SEXUAL RELATIONS AND MARRIAGE

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What is the function of marriage in our society?

Marriage has many functions. It gives social, legal, and religious sanction to the desires of most adult men and women for children, for emotional and physical closeness, and for the enjoyment of sexual intercourse. From a sociological point of view, marriage confers status and both defines and sharpens the roles of men and women with respect to each other and the community. Legally, marriage protects rights and sets obligations between the sexes and between parents and children, particularly as to the "name" and as to holding and disposing of private property.

Marriage initiates and perpetuates the family system of child rearing, and this is a cornerstone of civilization as we know it. The mental health and successful adaptation to society of each individual depends upon his having, from birth to adulthood, both parents living harmoniously together throughout these formative years. Most authorities agree that there is a direct correlation between unhappy or broken homes and juvenile delinquency and crime.

Few people remain unmarried without feelings of inferiority, shame, or guilt. The same feelings assail many married couples without children. Approximately two-thirds of all divorces involve childless couples. This is partly, of course, because conflicts appear before there are children, but partly also because of a sense of incompleteness without children. The unmarried or childless person often judges himself more harshly than do his friends and associates, but his shame or guilt nevertheless reflects common social attitudes.

What are the elements of a good marital relationship?

The family, as an institution, appears to be in transition from a patriarchal to a democratic form, i.e., from a Lord-and-Master autocracy to a community of equals. There is still considerable discus-

sion, however, as to what form of social organization, including marriage, best meets the "instinctual" and other basic needs of men and women. So far as a given marriage is concerned, the most important elements, perhaps, are those of mutual acceptance, agreement, and free communication leading to understanding. Marital partners, in a word, should be in essential agreement upon fundamental values, should accept the inevitable individuality of each other, and should be able to talk freely between themselves about all matters affecting the solidarity of the marriage and the welfare of the family.

It is remarkable how often Prince Charming turns out to be the boy next door. This is not so astonishing, however, when one recognizes the importance of homogeneity as to race, religion, social class, cultural traditions, age, and even community for successful marriage. A small college, once known as the "matchbox of the East," had a very high percentage of marriages among its graduates, and very few divorces. The students came—for the most part—from very similar backgrounds as to social and economic status, religious tradition, geographical locale, and intellectual as well as general cultural aspirations. Most authorities agree that the one set of facts is explained by the other.

In addition to sociocultural factors there are, of course, important psychological ingredients in a good marriage. These include relative emotional maturity and freedom of emotional expression. It is too pat to say that one should marry for healthy rather than for neurotic reasons, but this does highlight the psychological elements involved. Good marital partners will complement each other as regards some emotional needs, and to this extent there is truth in the old dictum that "opposites attract." In most respects, however, it is probably better if "like seeks like" in the realm of social, economic, and general family goals. The most successful marriages combine just the right amounts of "likeness" and "oppositeness" for closeness, sexual gratification, child rearing, and continuing emotional and intellectual growth.

What are the reasons why women desire marriage?

Women desire marriage for a multiplicity of satisfactions that a good marriage provides. The most important reason for many women is the wish to have children. Helene Deutsch and others who have intensively studied female psychology point out that many women find their complete and ultimate fulfillment in pregnancy, childbirth, and child rearing. The charm and beauty of such women is fully apparent

only after the birth of a child. Other women, equally "normal" and emotionally healthy, are able to achieve a comparable realization of emotional "needs" in erotic preoccupations, in art, in dedicated work, or in predominantly masculine pursuits. In any case, women generally seek marriage also for the closeness, the companionship, and the sexual gratification it provides under circumstances of greater freedom and security than otherwise. There are, in addition, factors of economic security and social status. The woman with children needs such protection, and most women without children find it desirable. For the vast majority of women, therefore, powerful biological and psychological forces combine with socioeconomic pressures to make marriage vastly more attractive than its alternatives.

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What are the reasons why men desire marriage?

It is generally assumed that men have less of a stake in marriage than women, but the goals of most make their commitment as strong as women's. Men, too, need closeness, companionship, and love. The majority want these in conjunction with a home and children. They are willing, if not always eager, to achieve these satisfactions (together with sexual pleasures) within the framework sanctioned by our culture. Men, too, may find the fulfillment of their masculinity in their ability to have children and provide for their development to maturity. Thus, marriage usually coincides with and enhances the attainment of a variety of social and emotional goals. Men desire marriage, in short, because—in our culture—it offers the maximum promise of satisfaction for a complexity of biological, psychological, and socio-cultural goals. Despite the chance that "you can 'ave it all, and not get 'ooked," the odds favor marriage.

Why do some people choose to remain unmarried?

A complete answer to this question would distinguish conscious and unconscious reasons. It might be argued that no one in our culture chooses to remain unmarried and that a conscious decision of this sort is really dictated by unconscious feelings of guilt about sexuality, or of fear and hatred toward the opposite sex, or of deep insecurity with respect to oneself. The choice of the celibate life is made in the face of powerful social forces and such a choice is applauded, in our culture, only if there is a sense of renunciation for the sake of great artistic, social, or religious purpose. In general, if one is not married to a spouse, one is expected to be married to a cause.

One cannot, of course, be dogmatic about such matters. The social goals of happy marriage are not necessarily the total goals of a culture. Those who marry "give hostages to fortune," and those who do not—historically, at least—sometimes become saints or martyrs, discoverers or philosophers, scientists or creative artists of the highest genius. The person who "chooses" not to marry may well be neurotic, however, and is certainly socially deviate, but these are by no means the only criteria by which we evaluate his place in our culture.

Are there some individuals who should never marry? Why?

It is easy to assert that certain persons should never marry. In practice, however, most authorities are reluctant to be categorical. In most states, for example, marriage licenses will not be issued to actively syphilitic individuals or to those who are manifestly *non compos mentis*, but these, obviously, may be temporary rather than permanent contraindications to marriage. Hereditary feeble-mindedness and "incurable" insanity or epilepsy are reasons for legal sterilization in many states, but the legal "capacity to give consent" may be all that is required for marriage. One may therefore distinguish those who should not have children from those who should not marry at all, but legal definitions in either area are most difficult because of actual or potential threats to civil liberties.

If one cannot dictate, one may nevertheless advise. Considering the probable fate of the marriage and the social consequences, most authorities recommend that the following should not marry: (1) persons with inherited degenerative diseases; (2) the feeble-minded who require institutional care; (3) chronic epileptics who need constant supervision; (4) persons who have chronic or recurrent, severe (psychotic) mental illnesses; (5) confirmed homosexuals; (6) chronic, severe alcoholics; (7) persons of adult years who have never achieved and show no promise of emotional and intellectual emancipation from parents or parent-substitutes; (8) those who, for whatever reason, cannot tolerate the restrictions of marriage; and (9) individuals so dedicated to causes or careers as to preclude the kinds of emotional commitment to another person usually required for marriage. Ideally, therefore, persons should not marry who do not meet certain standards of eugenic suitability, emotional maturity, and general capacity for social adaptation. In practice, however, the "expert" has to gear his advice to the particular individual and the specific situation.

Why do some persons marry at an early age?

The phrase "at an early age" should be thought of here as referring mostly to "teen-age marriages," but in a broader sense, it might apply to any impulsive or ill-considered marriage. Age is not the sole criterion, but it is nevertheless true that the "mortality" rate of early marriages is high. The old adage is still valid: "Marry in haste and repent at leisure."

Reasons for early marriage include the following: (1) the girl is pregnant; (2) one or both partners wish to escape disagreeable homes; (3) one or both partners are in rebellion against parental discipline or parental expectations; (4) the gallant boy wishes to "rescue" his girl from some unhappiness; (5) competition in dating is felt as too stiff, and "going steady" does not provide sufficient security; and (6) the real or imagined threat of military service for the boy gives rise in the girl to fears of becoming an "old maid," or in both boy and girl to fears that their happiness will not survive a long separation. Other, more neurotic reasons include: (1) flight from unconscious homosexual tensions; (2) fear of leaving the parental home and facing adulthood alone; and (3) a wide variety of emotional conflicts related to excessive narcissism and dependency strivings, for which marriage hopefully offers a solution. There are, of course, valid reasons for early marriage, particularly when both partners are emotionally mature, when the relationship has been tested by friendship and courtship of reasonable duration, and when other conditions are present—similarity of backgrounds, parental approval, etc.—that usually make for successful marriage.

What are the effects of early marriage?

Everything depends, of course, upon the relative maturity of the couple and their capacity for dealing with the restrictions as well as the delights of marriage. The prevailing pattern in early marriages is for one or both of the couple to continue in school, or to work, or both. Almost every university campus nowadays has young families, including children, in which both husband and wife work, go to school, and share in child care and homemaking. Financial support from the parents of the young couple is taken for granted, at least during the years of continued schooling.

Under favorable circumstances, the young couple "settles down," gives aid and comfort to each other, and successfully meets the challenge of their manifold undertaking. They enjoy together the excite-

ment of exploration and the fruits of achievement, and, in addition, they have a good deal of fun. Frequently, of course, the marriage falters or breaks down because the load is excessive and the demands too great. The difficulty with most teen-age marriages is that the personalities of the youngsters themselves are still too much in flux; their impulses are very strong, but their ego controls are still relatively weak. Moreover, they are likely to have rushed into marriage before the phase of nervous, anxious, and ambivalent romantic infatuation has resolved itself into a more solid and enduring "companionate" love. Beyond this, if the marriage has been largely a flight from some unhappiness or a rebellion against parental controls, then the young couple's expectations from marriage are likely to be grossly unrealistic and their emotional demands upon one another destructively excessive. This sort of thing happens at all ages, as any marriage counselor can testify, but although the teen-ager often has an advantage in resiliency, he is usually at a disadvantage as to stability, emotional maturity, experience, and the capacity to accept life's harsh realities.

What is sexual compatibility?

Sexual compatibility denotes a relationship in which sexual partners find a maximum of enjoyment, gratification, and fulfillment and a minimum of disappointment and frustration. The ideal of sexual compatibility is that of two people, madly in love, having simultaneous orgasmic ecstasy every time they have sexual intercourse, and ". . . 'tis a consummation devoutly to be wished." Students of sexuality know, however, that there are many forms and degrees of "being in love" and of "sexual gratification," and that sexual compatibility is a matter that admits of many variables. In a narrow sense, sexual compatibility refers to the mutual physical gratification found in sexual intercourse; in a broader sense, sexual compatibility implies a happy admixture of closeness, tenderness, mutual enrichment, and sexual pleasure between two sexual partners. They usually go together because the one nourishes the other.

What is trial marriage? What are the opinions of professionals on trial marriage?

Trial marriage is a trial at marriage without the legal or clerical marriage service. The famous Judge Benjamin B. Lindsey of the Juvenile Court of Denver (in the 1920's) once shocked the nation by advocating legalization of trial marriages. A variation—the "com-

panionate marriage"—would include legal birth control, divorce by mutual consent if there were no children and no financial or other economic obligation on the part of either husband or wife toward the other.

There has been relatively little discussion of "trial marriage" in the past twenty-five¹ or thirty years. It is unlikely that today's mental health experts have given the matter much thought. One reason, undoubtedly, is that "trial marriage" of sorts has become so common without legal sanction. We know from the Kinsey reports that while about 40 per cent of women born prior to 1900 had premarital sexual intercourse, the figure for those born after 1900 is close to 60 per cent. Moreover, of those who had premarital sexual intercourse twenty-five times or more, 64 per cent had it mostly in the nude, i.e., under circumstances at least approximating the privacy of marriage. Premarital sexual intercourse is, of course, no real trial at marriage, but it is nevertheless true that today's "dating behavior," much more than the old-fashioned courtship, often approximates a fairly effective, though unofficial, trial marriage. Even this, however, is hardly the same as living together "in sickness and in health" over a long period of time.

Another reason for decreasing interest in legalized trial marriage, perhaps, is that it is so easy—in many states—to get a divorce. If a marriage is not going well, particularly if there are no children, evidence of "incompatibility" or "mental cruelty" is sufficient to dissolve it. In effect, therefore, changing social attitudes and customs have diminished the pressures for legal trial marriage.

The dangers of unsanctioned trial marriage, i.e., premarital sexual intercourse or "living in sin," include disease, pregnancy, feelings of guilt, fear of exposure, and so on. These hazards have been somewhat mitigated by contraception, antibiotics, and motels, but the possibility of emotional complications remains. One partner may simply enjoy promiscuity while the other is looking for a mate. One may fall in love, and the other not. "Trial marriage" under these circumstances is little more than a trial at a sexual relationship, and although this may prove something, it does not prove everything as to how a marriage would go.

Legalized trial marriage would offer many advantages over clandestine affairs. It would enable prospective marital partners to live together and to have sexual intercourse under conditions approximating marriage. It would therefore be a much fairer "trial" than is now generally possible. At the same time, however, serious drawbacks

would remain. Trial marriage would be a continuation of the courtship, i.e., both parties would still be "on their best behavior." Moreover, there is always conscious or unconscious resentment at "being on trial." It is therefore difficult to know how much would be proven by trial marriage, particularly since the crucial test of most marriages comes with the arrival of children. Finally, the whole notion of trial marriage—particularly if it implies legalized contraception and divorce by consent of both parties—is abhorrent to the most powerful religious groups and, therefore, as a matter of practical politics, could not become legal for many years. In any case, there is no consensus about trial marriage (and very little current discussion) among experts in mental health fields. The more scientific of these experts would doubtless want considerably more data than are presently available before committing themselves to an opinion.

What is the function of the honeymoon? Can it have undesirable effects?

The honeymoon permits the newly married couple to get better acquainted. From a social point of view, it accelerates the transition from individuality to mutuality, from what is "mine or thine" to what is "ours." The sexual relationship is now legally and socially sanctioned and occurs, often for the first time, under circumstances of real privacy, security, rest, and freedom from distractions. The wedding night can, of course, be a nightmare if the young couple is exhausted, homesick, and anxious, and if the first sexual experience constitutes what has been termed legalized rape. Ideally, the honeymoon calls for as much careful planning as the wedding itself and as much advance awareness of its possibilities for good or ill.

It is generally agreed that the bridal couple should plan the honeymoon together or that, in any case, the plans should not involve surprises for the bride that will do violence to her taste, her *savoir faire*, or her wardrobe. It should enable the newlyweds to be wrapped up in each other and therefore should not be combined with a convention or safari. Devoted to fun—in order to be a memorable time—it should nevertheless permit relaxation, repose, and mutual planning, and exploration of both familiar and new interests. If it involves something of a splurge, it should prudently not exhaust the family coffers, unless, of course, the young couple can cheerfully subsist on hamburgers for months afterward. There will be great individual variation, of course, depending upon the couple's maturity, their sophistication,

and the quality and duration of their friendship and courtship before marriage.

Are sexual relationships reflected in most aspects of marriage?

Yes, and vice versa. Advocates of sexual emancipation often assume that as the sexual relationship goes, so goes the marriage. It is probably just as accurate to state that as the marriage goes, so goes the sexual relationship. Actually, the sexual relationship and all other aspects of marriage are manifestations of a total interpersonal interaction. This interaction is not limited to the marital partners; it includes also children (if there are any), in-laws, and friends. Gratifying sexual relationships sustain a marriage and mitigate the stresses and strains of family life. Unfortunately, however, it can work the other way so that the demands of child rearing, the energies devoted to the care of in-laws, or the jealousies and competitiveness sometimes arising from social life adversely affect the sexual relationship. Certainly, a mutually satisfying sexual relationship may be the most important ingredient in a happy marriage, but it may also be only one of several important factors, or it may not be a significant factor at all.

Can marriage be successful without strong sexual relationships?

Yes. Marriage serves many purposes and satisfies many needs. Although sexual gratification is an important component of most marriages, it is nonetheless true that happy marriages exist without sexual gratification. Age is a factor, of course, but so also are various emotional needs having to do with closeness, tenderness, sharing, and for example, rearing children or other joint creative projects.

The term "strong" sexual relationships suggests other considerations. It has already been indicated that satisfying sexual relations do not necessarily take the form of dramatic orgasmic experiences. It is a clinical fact, moreover, that some of the most climactic simultaneous orgasms are achieved by individuals who deeply fear and hate each other, the physical experience expressing a passion more tinctured with rage than with love or tenderness. The ideal goal of marriage may therefore be one that includes intense sexual gratification and fulfillment for both partners, but there are—be it said again—many happy marriages in which less spectacular sexual pleasure is the rule and is no more valued than the gratification of other physical, emotional, and intellectual needs.

What is the range of frequency of sexual intercourse in marriage?

The extreme range is from no intercourse at all to several times during any twenty-four hour period. Relatively few young married women—less than 1 per cent, according to the Kinsey report—go without sexual intercourse entirely, and most of these few are married to sick, crippled, or overtly homosexual men. The majority of young married couples have intercourse two to three times a week. Between the ages of thirty-one to thirty-five, once or twice a week is “average”; after forty, the frequency drops to about once a week; and after fifty, intercourse as often as once a week is the exception, although frequencies up to eight times a week were reported to the Kinsey group.

What are the normal sexual activities in marriage?

Authorities differ as to what are “normal” sexual activities. Some say that anything is normal that both partners find gratifying. Others amend this to state that anything is normal in the foreplay provided that it leads to sexual arousal and then culminates in “normal” intercourse, i.e., the penis fully penetrating the vagina with subsequent orgasmic climax or, at least, mutual gratification and relaxation of sexual tensions. Ideas as to what is “normal” vary, of course, with preconceptions as to whether sexual intercourse is primarily for procreation, or for pleasure, or for both, and as to its proper place in the totality of the marital relationship. What is normal for a given marriage is determined, to a considerable extent, by the goals of that marriage.

How important are the techniques of sexual intercourse?

Very important, and yet never to be taken too seriously. For most couples the techniques of lovemaking are those that lead to sexual arousal followed by vaginal intercourse. Each couple has to discover from experimentation and experience the forms and patterns of foreplay that are most enjoyable and effective for them. Men sometimes have to learn that women are generally not as easily or quickly aroused as they themselves. Physical stimulation is more important for women while psychic stimulation is often sufficient for men. “Erogenous zones” for both sexes include lips, ears, neck, fingers, and thighs, as well as nipples (particularly for women) and genitals. The clitoris, moreover, corresponds to the penis in erotic sensitivity and should not be ignored either in the foreplay or in the position of intercourse.

The woman, on her part, may have to learn that she may be active in initiating and taking part in lovemaking (provided she does not precipitate ejaculation prior to penetration) and that, in general, her acceptance of her own sexuality and of her sexual partner may well be as important for him as his for her. Both partners will respect the aesthetic sensitivities of the other but, if necessary, will make an effort to overcome the sorts of prudishness and inhibition that represent a carry-over from early masturbation guilt or other attitudes not properly attached to adult sexuality. Both partners, also, will do well to avoid what has been called "orgasm worship." The criteria for sexual gratification are overall pleasure followed by relaxation, and whatever leads to these is "good technique."

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Are any sexual activities, within marriage, detrimental to mental or physical health?

In general, no sexual activities are detrimental that give pleasure to both partners and that are followed by relaxation and repose. By contrast, sexual activities that are imposed upon one partner by the other, that arouse resentment, shame or guilt, or that result in tension and frustration may well be emotionally and even physically detrimental. For example, couples sometimes use coitus interruptus, i.e., interruption of intercourse before the man ejaculates as a contraceptive measure. This may leave one or both partners with dammed-up sexual tension and dissatisfaction in every sense of the word.

Considerations of mutual consent and mutual gratification are valid not merely for the sexual relationship, but also for the marriage as a whole. When the relationship is disharmonious and destructive, it is often difficult to determine whether the sexual life (in the narrow sense of the term) is at fault or whether there is some more pervasive incompatibility. If marital partners are able freely to discuss their likes and dislikes, to experiment and thereby work out patterns of sexuality that are mutually satisfactory, their activities are not likely to be detrimental to either. Excessive or neurotic demands or inhibitions on the part of one partner, however, are likely to lead to frustration and unhappiness for both. (See *Frigidity; Impotence*)

Can infrequent sexual activity be detrimental to an individual's physical or emotional health?

No, not in and of itself. Much depends upon the individual's sexual needs and expectations, as well as upon the frequency of arousal

and the variety of outlets available to him. In marriage, both partners—because of innate capacity, occupation, other interests, age, or other factors—may be quite content with infrequent sexual activity. Difficulties arise if the needs of one differ markedly from those of the other or if they have unrealistic ideas as to what is “normal.” A man, for example, with an excessive need to “prove” his potency will hardly be compatible with a frigid wife. Or, a couple—otherwise happy—may drive themselves into a frenzy trying to achieve an ecstasy they have read about or imagined. Each couple must find its own sexual pattern. Even in marriage the situation may, for one reason or another, be essentially that of celibacy, and the solution may be in spontaneous outlets such as nocturnal emissions or orgasms. Frequent arousal without some sort of consummation can, of course, be detrimental if only in terms of tension and dissatisfaction; here again, the situations are comparable to those of frigidity and impotence.

What are the most common sexual problems in marriage, aside from sterility, frigidity, or impotence?

Sexual problems, including those mentioned in the question, range from those caused by ignorance or thoughtlessness to those arising from unconscious neurotic attitudes or conflicts. One set of problems, already mentioned, stems from overly rigid attitudes about lovemaking or perfectionistic expectations as to the sexual response. Another set, closely related, derives from an overemphasis upon physical gratification at the expense of closeness, tenderness, and manifestations of mutual acceptance. It helps sometimes to remember that sexual intercourse is a psychosexual relationship, not simply a physical one.

Difficulties arise when one partner is interested in intercourse and the other is not. This is inevitable at times, and is “bad” only if the other partner is unduly wounded, the “wound” being mostly to his narcissism. Couples often make the mistake of attempting intercourse when unduly tired, preoccupied, or distraught. Gratifying sexual intercourse under such circumstances can, of course, be a comfort and a source of renewed hope, but the percentage of failures is bound to be high. Unvoiced fears of pregnancy, the presence of children in the same or adjoining room, or any other situation that precludes complete privacy and abandon, all tend to interfere with sexual happiness. Many—perhaps most—young couples in our culture require time and patience to overcome early attitudes of shame, fear, and guilt with respect to seeing, touching, and otherwise enjoying each other’s bodies,

in learning and creating together the optimum conditions for mutual physical enjoyment, and in working out the most satisfactory total emotional and physical interaction that spells psychosexual gratification. (See *Frigidity; Impotence; Sterility*)

What are the sensible ways of handling these problems?

The first step, perhaps, is discussion at home. The couple that can acknowledge a problem and talk about it frankly and dispassionately will frequently find a solution. Beyond this, reading may offer guidance for those who have not been well prepared for marriage. Recently published textbooks for high school and college courses on "Marriage" or "Marriage and the Family" are generally frank, thorough, and realistic. For untutored couples, such books can be both informative and reassuring. Marriage counseling is a next step to be considered. Where to turn is often a problem, but possibilities include the family doctor, the minister, rabbi, or priest, a family service or counseling agency or—for such problems as frigidity, sterility, and the like—a gynecologist, psychiatrist, or clinic devoted to such problems. Effective help may take the form of information or advice and range all the way to medical—including psychiatric or psychoanalytic—treatment. (See *Marriage Counseling*)

How do the sex drives of husband and wife compare at different ages? What does this demand in sexual adjustments?

There is, first of all, a good deal of individual variation regardless of age. Due to innate biological nature or to the circumstances of rearing, some individuals have a good deal more sex drive than others. Other variables include general physical health, occupation, extent and nature of intellectual, cultural, and community interests, and of course, degrees of neurotic conflict. The fact that couples over fifty years of age vary in the frequency of sexual intercourse from zero to eight times a week indicates both the range of variation and the fact that age is but one of multiple factors.

From a statistical point of view, the Kinsey reports came up with the puzzling facts that men reach the peak of their sexual interest and potency at about the age of twenty, and thereafter gradually decline, whereas women—much slower to develop fully their capacity for sexual response—do not reach the zenith of their sexual interest and responsiveness until thirty-five or even forty, a state of affairs that persists well into the period when men's potency is very much on the decline. This

would appear to indicate a situation inimical to perpetuation of the species. Certainly it would be odd if men were most potent when women were least interested and responsive, and vice versa.

Subsequent studies have pointed up other factors. It would appear now that although men do indeed achieve maximum potency early, there is still a gradual increase during the twenties and only a very gradual decline from about thirty to forty-five. Women, on their part, approach their peak by about the age of twenty-five and the curve of their interest and responsiveness closely parallels that of men from that age onward. It seems evident that the data about women depend considerably upon the sample. Women who are exhausted by children or careers, who are annoyed by the use of contraceptives, or who are constantly fearful of pregnancy, for example, are likely to vary markedly from those, on the one hand, who are largely free from these influences in their younger years or, on the other hand, who achieve such freedom with the menopause, and perhaps for the first time, enjoy uninhibited sexual intercourse. In any event, it seems that the principal differences are in the early years—say, from the ages of eighteen to twenty-five—and that it is up to young husbands to understand the situation and await patiently the time when their wives will “catch up.” And if it does turn out—after the age of forty-five or so—that the husband’s potency declines while the wife is still at her peak, then it will be her chance to be patient and understanding.

Is infidelity a sign of psychological upset?

This is certainly one possibility. The term “psychological upset” needs further definition because it may imply anything from a spiteful reaction during a quarrel to deeply neurotic conflicts infusing an entire marriage. Also, a husband’s emotional upset may cause him to be unfaithful, or his wife to be so, and vice versa. The range of possibilities may be suggested by a few examples: (1) Husband and wife quarrel, husband goes to a bar, gets drunk, and picks up a prostitute. (2) A couple has a child, the husband cannot tolerate his wife’s devotion to the infant and so turns to another woman for a more “exclusive” relationship. (3) Husband and wife are approaching middle age, are (perhaps unconsciously) “threatened” by declining sexual attractiveness and prowess, and (one or both) start having affairs to “prove” that nothing has changed. (4) After a few years of marriage, the wife becomes a “golf widow” or “business widow” or some other kind of “widow,” and so turns to someone else for attention, admiration, and

sexual gratification. (5) Unconsciously one or both marital partners have married spouses who can be admired, adored, and respected, but with whom sexuality is (again unconsciously) felt as gross, dirty, and forbidden; sex is therefore enjoyable only with a "degraded" love object, a "prostitute type" or the male equivalent. Most authorities would agree that psychological upsets—superficial or deep—exist in all of these situations, and dozens of others that might be listed.

Can there be infidelity without extramarital sexual activities?

There are several definitions of "infidelity," but by any of them it can occur without extramarital sexual activities. By the same token, however, there may be extramarital sexual activities without infidelity. As has been stated, there can be many kinds of marriage, but there must always be an understanding, an agreement. Infidelity consists in abrogation of an agreement, treachery with respect to an understanding, and deceit. In a narrower sense, of course, infidelity means any violation of the marriage contract, and here everything depends upon the terms of the contract and how they are understood by the pair that has agreed to them.

It is hardly to be expected that all of one's physical, emotional, and intellectual needs will be fulfilled by or with one's spouse. This is why couples have a social life with other couples and why husbands spend time with other men, and wives with other women. The situation becomes more complicated when a husband turns to "another woman" (or the wife to another man), but many things are possible within the framework of a marriage provided there is mutual understanding and consent. Thus, infidelity is partly a matter of the formal marriage contract and partly a matter of how a married couple has agreed to understand and abide by it.

What are the usual causes of infidelity?

Infidelity is most commonly the result of a search for something—sexual gratification, companionship, a sense of acceptance, etc.—not found in the marriage. It is the result of sexual incompatibility in the literal or in the broadest sense of the term. Often it represents an escape from the restrictions or responsibilities of marriage, and "incompatibility" serves as a convenient rationalization. Unconscious wishes for infantile or other neurotic gratifications are frequently the real motivating forces in a new infatuation or extramarital affair. The unfaithful man or woman has a "need" to deny unconscious homosexual

impulses or (often related) to keep "proving" his masculinity or her femininity. The neurotic "divided love object" is frequently involved; the spouse is highly respected and loved spiritually, but "gross" sexual strivings can be gratified only with other, degraded, and depreciated love objects. The unfaithful person is not uncommonly unconsciously in competition with his children, and he turns to an extramarital relationship in which (hopefully) he can be the "only one." In this as in many other ways, infidelity represents the pursuit of a will-o'-the-wisp, an unconscious attempt to return to the earliest, most gratifying relationship with an all-giving mother.

What problems might result when a wife uses agreement to intercourse as a reward, and refusal as a punishment?

The romantic belief that sex and love go together blinds us to the harsh fact that sex sometimes gets involved in power struggles and in the "war between the sexes." If sexual intercourse is part of a "reward and punishment" relationship between marital partners, it may only reflect the way both of them were brought up and may therefore seem the natural way to live. Unless such a wife has a docile school-boy for a husband, she has two strikes against the marriage. The husband's inevitable—conscious or unconscious—resentment will cause him to withdraw from her, and probably to retaliate. He may become impotent and he is likely to become unfaithful, in fantasy if not in fact. Divorce becomes a possibility. The use of sex as a weapon is, in short, not likely to make for a happy marriage, and indeed is not likely to happen with reasonably mature marital partners.

Can marriage be successful without the partners being in love? With one of the partners giving more love than the other does?

The answers to these questions must be equivocal. If one goes by surface appearance alone, then the answer to both is, "Yes." There are many successful marriages without the partners being in love, at least in any overt romantic sense of the term. Actually, romantic love may simply be infatuation—what one writer has called cardiorespiratory (palpitating and breathless) love—and a kind of adolescent illness. If love is defined in terms of companionship, friendship, mutual helpfulness and sharing, or even mutual convenience—with or without gratifying sexual relationships—then the answer becomes, "No." There must be some kind of love for a marriage to work.

From a different perspective we can imagine a "successful marriage"

based upon hate. Here we assume the "successful" interaction of basic needs not customarily thought of as love.

Situations of unequal giving and receiving likewise depend upon the emotional needs of individual men and women. A woman, for example, who gives everything and gets very little in return may nevertheless be deeply gratified (unconsciously, perhaps) in terms of strong maternal impulses or masochistic traits. Appearances are notoriously deceptive, and we have to assume that most marriages that last are successful marriages—whatever may be on the surface—because of the fact that the unconscious forces that brought the couple together in the first place are still very strong. A common example is that of the wife of an alcoholic husband—a familiar figure in social agencies. She comes frequently, she wants help, she plans to separate from her husband if he cannot be cured, but over the years very little happens except that history repeats itself. To a discerning eye it soon becomes apparent, in such cases, that the wife gets unconscious vicarious gratification from her husband's drinking, or (again unconsciously) gloats over his weakness and impotence, or unconsciously needs (even "enjoys") the punishment she absorbs from this cross she has to bear. Some marriages work out very well, then, with the husband or wife the all-giving "mother" and the other one the pampered child.

Can a marriage be successful when a career or job consistently requires most of a person's interest and energy?

This kind of situation puts a tremendous strain on a marriage. Again, however, there are many factors to consider. If both husband and wife have absorbing careers, both may be satisfied with what energies remain for the marriage. This is quite possible if there are no children, if the children are grown, or with children, if there is ample money for servants. If it is the husband who is so absorbed in business or other career, this may bother the wife very little if she has children or other interests of her own, although she may insist on taking her husband away for an occasional vacation. It makes a lot of difference, too, whether "home" is an apartment or a house and whether going to the office takes minutes or hours. In other words, the burdens of a busy career will affect a marriage less if other demands for time and energy are minimal. Generally speaking, however, a successful marriage itself takes time, energy, and interest, and a job or career that consumes most of these is likely to destroy the marriage, whether it is formally broken or not.

Can a marriage be successful when the husband and wife must be apart frequently and for considerable periods of time?

There are many such marriages. Frequent or prolonged separations are difficult, and may prove "fatal" for some; but they certainly do not preclude successful marriage. Despite the hazards there are happy marriages among traveling salesmen, actors and actresses "on the road," Navy personnel, fishermen, merchant seamen, professional baseball players, and a host of others who must adjust to frequent or long separations. Having an invalid mother-in-law in the home, for example, might put just as great a strain on a marriage. These separations or "strains" are but some of many elements in marriage, and they must be weighed along with community patterns of living, individual capacities for abstinence, the presence of children at home, parallel careers, and so on.

Is it possible for a husband or wife to "outgrow" his or her mate intellectually, emotionally, or socially? What can the partners do to improve such a situation?

"Washington," said the wife of Justice Oliver Wendell Holmes, "is full of famous men, and the women they married when they were young." Whatever one makes of this mot, it does illustrate the point that circumstances often affect the mutuality of marriage. A young doctor after ten years of higher education marries a pretty nurse who completed high school prior to nurses' training. They have in common their youth, their physical attraction for each other, and their professional work. A few years later all they have in common may be their children. Another doctor, on the other hand, marries a graduate of Bryn Mawr and the Junior League only to divorce her for his office nurse. One may "outgrow" the other, or their paths may simply diverge.

The best treatment is prevention. Granting the exceptions, marital partners should have similar backgrounds—similar, that is, as to race, age, economic status, education, and cultural traditions. Despite the claims of "true romance," the odds are against the prince who marries Cinderella, the heiress who elopes with the chauffeur, or the aging dean who marries a co-ed. Statistics favor the lad who marries the girl next door.

If a marriage begins with a community of interests, it is unlikely that one partner will "outgrow" the other. When this appears to happen, it is frequently because one partner forges ahead because of neurotic ambition or the other lingers behind because of neurotic helplessness.

A reasonably mature couple will consciously counteract what tends to draw them apart by cultivating what they can share, whether old interests or new. The brilliant young executive and his "high school sweetheart" wife, or the glamorous movie star and her less scintillating husband, can still—if they will—go dancing together, bowl together, take up French together, and travel abroad together. It is true that marked personality changes sometimes occur in one partner and not in the other. This may follow going off to war, or rearing children, and sometimes after psychoanalysis. Such changes affect the emotional balance of the marriage and may, indeed, completely disrupt it. Perhaps "outgrowing" is too convenient a word, a dubious rationalization. In any case, if such a couple cannot themselves prevent disruption, they need marital counseling or even psychiatric treatment.

SLEEP

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What is sleep?

Sleep is a normally occurring periodic state of rest for both mind and body, during which consciousness and ability to act are more or less completely suspended.

How can you tell when someone is asleep?

There are three ways of judging the presence of sleep:

1) *Subjective*. When a person becomes progressively drowsy and then loses track of his surroundings and the passage of time (in the absence of any disease or intoxication), he usually considers himself to have been asleep until the resumption of his awareness of the environment.

2) *Behavioral*. Closure of the eyes, increase in the depth and regularity of breathing, slowing down of bodily functions (including breathing and heart rate), cooling of the skin, relative immobility except for occasional changes in position, lack of response to events in the environment, and yet relatively easy arousability to a state of clear consciousness, all combine to give a behavioral diagnosis of sleep, especially if combined with the subjective statement of the sleeper as described above.

3) *Bioelectric*. This is the most objective definition of sleep, although even here an absolute line cannot always be drawn between marked drowsiness and early or light sleep. This method involves the recording of electrical brain waves which can be picked up from metal wires glued on the scalp. The small electrical impulses put out by the brain travel along these wires, are amplified, and are recorded as wavy lines on a moving sheet of paper. The recording machine is called an *electroencephalograph*, and the record of the brain waves is the *electroencephalogram* or E.E.G. The E.E.G. is picked up from all over the surface of the head and during deep sleep it consists mostly of large, slow waves. As sleep lightens, the waves become smaller and faster. When a person is awake the waves are small and smaller and display a



fairly reliable rhythm (about ten small waves per second) in the normal person. As drowsiness recurs, occasional large, slow waves reappear and become interspersed with sharper waves ("sleep spindles") as the transition into sleep takes place.

Is sleep necessary?

As far as we know, it is impossible for animals to survive without sleeping, even though it is possible to withstand limited periods of sleep deprivation.

What amount of sleep does the average person require?

People show great individual differences in this respect, and no adequate objective means of evaluating sleep requirement has yet been developed. The need for sleep varies during the individual's lifetime, beginning in early infancy. The newborn infant sleeps most of the time; older babies may sleep twelve hours out of twenty-four. During childhood the sleep requirement steadily diminishes until a leveling off takes place in adolescence. The average young adult requires approximately eight hours of sleep. The range in the adult population appears to be between six and nine hours, the average falling at around seven and one-half hours. Older people apparently require less sleep at night, although they frequently take short naps during the day.

Why do different people need different amounts of sleep?

The individual's sleep requirement often appears to be related to factors such as temperament, body-build, and family characteristics. However, people can accommodate themselves for long periods of time to a relatively limited amount of sleep. It also appears that certain people habitually sleep (or appear to sleep) longer than their actual biological needs dictate. In some cases excessive sleep may be a form of escape from unpleasant life situations.

What effect does lack of sleep have on a person?

Complete sleep deprivation cannot be endured for long without marked mental symptoms occurring. A person who tries to stay awake becomes progressively drowsy, particularly during the night when he is accustomed to sleeping and when all his bodily processes slow down accordingly. If a person goes without sleep for two or three days, he begins to have brief lapses of attention ("microsleeps") lasting from one to three seconds, during which he is oblivious to his surroundings.

even though he may appear to be awake. Any person who is kept awake for more than four days and nights will inevitably show progressive and severe signs of mental disturbance. However, it is rare for a person to be able to remain awake for such a period of time without extraordinary motivation to do so; even then he requires help from other people and the use of chemical stimulants as well as other methods for constantly rousing himself. Forced sleeplessness is an ancient torture (known to the Spanish Inquisition as the *tortura insomniae*), and is brutally employed in modern times by police states to wring "confessions" from captives. (See *Brainwashing*)

Is there a typical mental illness due to sleep deprivation?

There are many individual differences in the form of psychiatric disorder that result from any form of stress, yet a general description of the psychosis of sleep deprivation can be given. During the first four days and nights there is a growing burden of drowsiness and an increasing frequency of "microsleeps." A sense of tightness or "pressure band" around the head often develops and creates the sensation that one is wearing a hat. Fine eye movements decrease and there is a tendency to stare. Illusions of movement may appear, such as vibrations of the wallpaper design, or fleeting "mice" or "roaches" glimpsed in the corner of the eye. As time goes on, two types of visual hallucinations are commonly experienced. The first to appear is usually in the nature of a pattern: grillworks, netting, filigrees, laceworks, cobwebs, rippling water, or geometric designs. The second type resembles a brief waking dream in which a complete imaginary situation is perceived. As sleep deprivation continues there is increased weariness, disinterest in the outside world, withdrawal, and preoccupation with bodily symptoms such as tingling sensations and muscular aches and pains.

After 100 to 120 hours of complete sleeplessness, periods of full-blown psychosis appear with progressive frequency. The visions become more prolonged and may be frightening. Auditory hallucinations and other sensations may supplement the visual ones. The person's face becomes elongated and masklike, with a characteristic furrowed brow and a hollow-eyed, suspicious stare. His thinking becomes markedly confused. False beliefs (delusions) gradually develop as the subject (now better called the "patient") becomes disoriented for time and place and finally may even be unable to identify the people around him. The clinical picture is that of a toxic delirium with features of paranoid schizophrenia.

Is lack of sleep always dangerous? How long do its ill effects continue?

In addition to the danger of the acute psychosis of sleep deprivation described above, latent mental illness may be precipitated by a prolonged vigil. One man who stayed awake for seven days and nights was not only delirious during most of the last half of his ordeal but for six weeks afterward suffered from lapses of awareness and periods of amnesia. Another man who stayed awake for over 200 hours developed all the signs of mental illness noted above; although the more severe symptoms abated within a day or two after his deprivation ceased, it was possible to measure some degree of impairment in mental functions as long as ten days afterward. Most normal people who suffer shorter periods of sleep loss will find that one good night's sleep appears to counteract most of the ill effects. But mental patients who were greatly improved have been found to redevelop their previous severe symptoms following a period of sleep deprivation.

Is sleepiness a sign of laziness or low intelligence?

Not at all. Some brilliant, productive people require nine or more hours of sleep routinely, while others report the ability to get by for long periods of time on five hours or less of sleep. By the same token there are mentally retarded individuals who are very restless and seem to have abnormally low requirements for sleep. Some mental defectives appear to be dull and lethargic, but the actual time they spend sleeping may not be abnormally high.

Can a person train himself to require less sleep?

It is unlikely that practice will alter any individual's biological requirement for sleep. However, a person may discover that he can get along on less sleep than he had previously supposed, without experiencing significant impairment in his performance. Ultimately, each individual's requirement asserts itself in terms of his actual craving for sleep and his resulting behavior.

Do physically sick people need more sleep than people who are healthy?

While many individuals suffering from physical illnesses require more rest than they would if they were well, they may not actually require more sleep. In fact, if their illness decreases the amount of physical exercise that they are accustomed to, their sleep requirement may decrease rather than increase. Of course, if exhaustion is a feature of their illness, an increase in sleeping is likely to occur.

Are sleep patterns the same in different human cultures?

There are remarkable similarities in the sleep patterns of human beings all over the world, although there are also differences which may be related to cultural and geographical factors. On the whole, the human appears to have adapted himself to life on a planet that rotates once every twenty-four hours and on which it is profitable to be active during the daytime when it is light and to rest at night when it is dark. This seems to have resulted in a more or less universal mental and bodily rhythm in which the metabolism is higher during the day and lower during the night. This rhythm is called the *diurnal cycle*. However, within the limits of the diurnal cycle, considerable variations can be found. In tropical climates a period of sleep during the heat of the day is common, with a resulting decreased nocturnal sleep requirement. In far northern regions, people appear to get along on less sleep during the precious and relatively few long days of summertime and to make up for it by sleeping for longer periods during the long dark winters. Not always without difficulty, workers who are employed at night are able to reverse their diurnal cycles, although the cycle continues to be twenty-four hours in length. It has been found that the length of the cycle in some individuals can be altered if the myriad and complex influences of man's usual twenty-four-hour day can be removed, but it has been difficult to accomplish such environmental alteration and further studies of its effects are needed.

Why does sleep sometimes seem more refreshing than at other times?

The subjectively satisfying quality of sleep is based on psychological differences that are best understood in terms of the individual's attitudes about what he is looking forward to when he wakes up. However, some physical factors may play a role. Sleep that is frequently interrupted may be less refreshing. Physical tensions may persist to a remarkable degree during sleep. Troublesome dreams may have a disturbing effect. Uncomfortable night clothes, extremes of temperature, and other environmental influences may diminish the restfulness of sleep.

One often hears strong opinions about the value of fresh air, bed-time snacks, etc., in aiding sleep. Are these things important?

Such factors appear to be based almost completely upon individual learning and experience. The attitude that one takes toward the sleep

situation unquestionably has considerable influence upon the pleasure and satisfaction one obtains.

Does everyone move around during his sleep?

Movements during sleep occur on the average of once every twelve minutes. They are unlikely to occur during periods of dreaming, but at the end of most dreams there is a major bodily movement of some kind. (See *Dreams*) Certain habitual movements during sleep (such as grinding the teeth or "bruxism") are considered to be manifestations of tension states.

Is sleep ever used to treat mental illness?

Yes, and this has been true since ancient times. Recently there has been a revival of interest in sleep therapy as a formal method of treatment in psychiatry. However, the term "sleep therapy" may be somewhat misleading. Treatment is accomplished, usually over a period of weeks, by the frequent administration of sedatives. A better term might be "stupor therapy," since the patient spends most of the time in a semicomatose state under the influence of medication. His state cannot properly be termed sleep. In the treatment of cases where exhaustion and sleep deprivation play an important role in the development of the illness, the curative effect of sleep will be dramatic. In chronic mental conditions the indications for sleep therapy are not too clear; varying results have been reported by different investigators. In minor psychological disturbances sleep is often most helpful, living up to its designation as "the balm of hurt mind."

Is hypnosis a form of sleep?

Hypnosis is not a form of sleep. The hypnotized subject is awake in terms of E.E.G. criteria. (See *Hypnosis*) However, when the subject is in the deepest levels of hypnotic trance he may make a transition into actual sleep, a transition which is determinable by E.E.G. criteria but which is imperceptible by behavioral criteria.

Can someone sleep too much for his own good?

Certainly this is possible in terms of psychological and social criteria. However, it is unlikely that a normal person can harm himself by the simple process of sleeping.

What is sleeping sickness?

Sleeping sickness is a form of encephalitis or inflammation of the brain, which causes prolonged periods of coma. The coma may resemble sleep, but it is not sleep as we ordinarily think of it. There is no sickness that is caused by excessive sleeping, and ordinary sleep does not become excessive as the result of any illness except certain brain diseases in which the sleep control centers of the brain are, themselves, affected.

Can people learn while they are asleep?

This is a disputed point. At the present time the most valid observations indicate that learning cannot be effected during true sleep. However, all of the time a person spends in bed may not be spent actually sleeping. Methods of "sleep teaching" that employ continuous tape recordings or similar devices may produce a certain amount of learning during those periods, between the time the person goes to bed and the time he arises, when the "sleeping" listener is actually awake by E.E.G. criteria.

Why do some people talk in their sleep?

We do not know the answer to this question, nor can we be certain that "sleep talking" is always related to a dream, although this seems to be the case. In fact, it has been found that some people apparently talk in their sleep during periods when they are presumably not dreaming. (See *Dreams*)

Why do some people walk in their sleep?

Except in small children, sleepwalking is likely to be related to an emotional disturbance. Sleepwalking, or somnambulism, usually involves a reenactment of events or fantasies from everyday life that have special significance. Somnambulism is related to certain other conditions (fugues, multiple personalities, amnesias) generally classified by psychiatrists as "dissociative reactions," a group of psychoneuroses related to the hysterical reactions. The sleepwalker's eyes may be open, but, as was observed of Lady Macbeth, "their sense is shut."

Why do some people wet the bed during sleep?

This is a normal phenomenon in small children. Control of the bladder takes longer to establish than control of the bowel, and oc-

casional bed-wetting (enuresis) may persist up to or even beyond the age of five in normal children. In such cases enuresis usually occurs during very deep sleep preceding the first dream of the night. Habitual bed wetters (enuretics) in late childhood or adolescence usually have an underlying emotional disturbance requiring psychiatric treatment. Adult enuretics present a special psychiatric problem. Detailed observations of such individuals reveal that their bed-wetting usually occurs toward morning, often during a period of actual wakefulness, by E.F.G. criteria, though behaviorally the person appears to be asleep.

It should be kept in mind that certain individuals who suffer from seizures (epilepsy) may lose control of their bladder as the result of an attack that occurs during sleep. This is not to be confused with enuresis.

Can seizures or epilepsy cause sleep?

The stupor that follows an epileptic attack is not the same as ordinary sleep. However, there is a form of convulsive disorder called *narcolepsy* which is manifested by occasional seizures of sleeping. Individuals suffering from this illness, which resembles epilepsy in some respects, are easily differentiated from the individual who is constantly falling asleep because of fatigue or boredom. The narcoleptic's attacks of sleeping are abrupt, are difficult or impossible to prevent without special medication, come at irregular times, and last for short periods. They are "fits" of sleep rather than periods of sleepiness. (See *Epilepsy and Other Paroxysmal Disorders*)

Do people often die during their sleep?

Yes, particularly the very old and the very young. In fact, it often appears that nature kindly provides for a gentle transition between normal sleep ("the death of each day's life") and that long sleep which is the final part of every life.

What is insomnia?

"Insomnia" is a term used to describe a person's inability to sleep when, or as much as, he would like. Normal people occasionally have nights when sleep will not come. a certain amount of insomnia is not harmful and should be disregarded. Persistent insomnia may be a symptom of an emotional disturbance. Anxiety frequently causes a form of insomnia marked by frequent awakenings during the night. Tension or strong feelings of anger and resentment frequently lead

to inability to fall asleep at the usual time upon retiring, although sleep may then proceed normally when it finally comes. The depressed person often finds himself awakening earlier and earlier in the morning, being unable then to return to sleep, and suffering from the most gloomy thoughts and hopeless feelings during the hours before dawn, when vitality is at its lowest ebb.

What should a person do if he suffers from insomnia?

Mild forms are best treated without medication. Caffeine, nicotine, and evening excitement are frequently the villains. Often a change in the routine of life, including regular exercise and wiser eating habits, will correct the condition. Persistent or more severe degrees of insomnia should be considered possible symptoms of illness, and the sufferer should consult his physician.

Are sleeping pills dangerous?

Of course they are. In the first place, any chemical that is capable of producing sleep is capable, in large enough dose, of producing death. Many sedatives are actually addicting in their qualities. (See *Narcotic Addiction*) Others, which have been called harmless or not habit forming, if used regularly become a crutch on which a person unhealthily depends. Recently there has been a regrettably growing tendency toward reliance on pills and capsules for the control of various normal functions (bowels, appetite, sleep, and wakefulness, etc.). There are many people whose entire daily cycle is controlled by a round of morning stimulants, daytime tranquilizers, and nighttime sedatives. This is a most unhealthy state of affairs. Except in the actual hospital or outpatient treatment of a psychiatric illness, such a regime is best avoided.

Is there anything important still to be learned about sleep? What kind of research is going on?

The mystery of sleep is one of the most challenging subjects facing science today. At the present time we have some understanding of the brain mechanisms that regulate sleep and wakefulness. However, we have no basic understanding of the nature of the sleep requirement itself. Does the brain use up some substance during the day which can only be replaced during sleep? Does something accumulate in the brain during the day which can be replaced during sleep? Does something accumulate in the brain during the day which is only eliminated

during sleep? What is the nature of the mental illness that inevitably accompanies prolonged loss of sleep? How do the various mental and physical rhythms interact with the diurnal cycle that regulates sleep? What is the significance of the periodic lightening and deepening of the sleep itself, and how does it relate to the so-called "dream rhythm"? Is sleep merely a vehicle for dreams, or are dreams merely a side effect of the periods of light sleep? What are the time limits of the periods we must spend sleeping in order for sleep to fulfill its restorative function (to knit up "the ravell'd sleeve of care")? How do we know when to wake up? Can some people set "inner alarm clocks," or remain deeply asleep through a thunderstorm only to awaken at a child's faint cry? If so, how does it work? Will men in space stick to a twenty-four-hour day, or will some new sleep-wakefulness time cycle emerge for them?

Do changes in sleep or dream rhythms reflect or predict some change in the mental status of psychiatric patients? Could studies of a person's sleep patterns enable us to foresee an imminent acute personality disorder? These and other related questions are now being asked, and answers are being sought by scientists in many centers, particularly in the Soviet Union, France, and the United States. It appears likely that important new advances in research on sleep, to be expected before men walk on the moon, will have great significance for the entire field of mental health.

SOCIAL ANTHROPOLOGY AND MENTAL HEALTH

by ROBERT N. RAPOPORT, P.H.D.
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What is social anthropology?

Etymologically, anthropology is the "study of man." It has a grand conception of itself as a discipline encompassing man in all his dimensions (biological, psychological, and sociocultural), in all his habitats (from Paris to Patagonia), through time (up from the apes). Social anthropology is the branch of anthropological study that seeks to formulate general principles governing man's social life from the more descriptive data of other branches, i.e., ethnology, linguistics, and physical anthropology.

What are the aims of anthropology?

There are various, sometimes contrasting, foci of interest within anthropology. One set of interests has had to do with the universals in human culture. This is in contrast to the interest in more specific diversities among human groups. To the extent that anthropologists have been interested in universals, they have taken the overall view of culture as a generally human phenomenon, of man as a single species, of evolution as a grand process encompassing the whole world. To the extent that they have been interested in comparisons, they have stressed diversity, emphasized unique features of particular cultures, and advocated the viewpoint that each culture must be understood relativistically, i.e., in terms of its own values and standards. Another set of contrasting aims has to do with the orientation of the total field. Those favoring the humanities as a model lean more toward the use of literary and artistic metaphors (e.g., themes in culture). This is in contrast with those who use the model of physics and choose their metaphors accordingly (e.g., equivalence structures, feedback mechanisms). The former stress the goals of enriching human understanding and wisdom; the latter emphasize classification, prediction, and control of the course of human culture.

What is the history of anthropology?

The origins of modern anthropology as a distinct academic discipline are usually considered to be marked by the work of Edward Burnett Tylor, whose book, titled *Primitive Culture*, was published in 1871. His definition of culture, which is the key concept around which most of modern anthropology is built, still remains the most generally acceptable one. Culture, he wrote, is "that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society." During Tylor's lifetime, there was a tremendous integrative effort, bringing together the scattered data that had been coming in through world exploration, trade, conquest, and proselytization. James G. Frazer and Robert R. Marett worked on religions, Alfred C. Haddon and Augustus H. Pitt-Rivers on art and technology, William H. R. Rivers and A. H. Morgan on kinship and social organization, etc. These scholars are referred to as the "classical evolutionists" because they sought to order their data on a preconceived evolutionary ladder of cultural development. The accumulation of knowledge in various fields felt to be integrally related came to be one of the hallmarks of modern anthropology, and still serves as the binding force among the currently recognized subdisciplines.

The next generation of anthropologists—developing early in the twentieth century—challenged the rigid schema of the classical evolutionists from several points of view. One influential set of challenges came from the group of anthropologists following A. R. Radcliffe-Brown and Bronislaw K. Malinowski in England, and Franz Boas in the United States. Radcliffe-Brown and Malinowski, both steeped in intensive field experiences with the rich fullness of life among primitive people and both impressed with the shortcomings of the historical reconstructions of the classical evolutionists, arrived at similar formulations. They stressed the merit of understanding sociocultural systems as integrated wholes functioning in a quasi-organismic mode, and satisfying or effective for their members not commensurately with their positions on an evolutionary ladder, but rather with their intrinsic functional properties. Both Radcliffe-Brown and Malinowski made great efforts to reorient at least the social anthropological branch of their discipline to more scientific conceptual frameworks.

Boas and his followers, who include such eminent workers as Alfred L. Kroeber, Robert H. Lowie, Paul Radin, Ruth Benedict, Margaret

Mead, etc., were similarly disenchanted with the classical evolutionist scheme. Their researches indicated that the earlier preconceptions of culture history simply did not hold up empirically. It seemed to Boas and his group that the many refutations they were finding of the classical evolutionist generalizations about human history made such grand schemes untenable pending further empirical study. They urged, in consequence, an intensive effort toward detailed historical reconstruction of particular culture sequences—only after which would it be possible to make adequate theories of man's cultural history.

What are the contemporary "schools" of social anthropology?

Broadly speaking, one can distinguish between the "functionalists," who have been especially influenced by Radcliffe-Brown and Malinowski, and the "neo-evolutionists," who have been interested in pursuing the classical evolutionists' goal of historical reconstruction through the use of improved empirical materials, following Boas. Functionalists, like Meyer Fortes and Raymond Firth, are preoccupied with a detailed understanding of how contemporary societies work. They eschew historical speculations and the construction of grand sequences of cultural development. However, the functional model underlies almost all social anthropological work, and the neo-evolutionists are not in any sense "nonfunctionalist," or "antifunctionalist," but devote their energies to somewhat different proximate goals. Julian Steward, who is the foremost exponent of this approach, performs functional analyses of his data, but is primarily interested in learning of the conditions that are necessary and sufficient for a society to develop from one "level of integration" to another more complex one. This understanding is based on actually observed sequences rather than logically and ethnocentrically plausible ones.

Another kind of distinction is between those scholars who confine their analysis to one level of abstraction only (e.g., Leslie White, who considers anthropology the study of "culture"), and those who use a multidimensional approach. The latter, generally designated the "culture and personality" approach, is most germane to the interest in socio-cultural factors in mental illness and health.

What is the distinction between culture and social structure?

Both culture and social structure are abstractions from the flow of patterned activity of people in social groups. In general, culture is the abstraction made to encompass what is done (the "heritage," the

“shared belief” system, the values, the products, etc., of a social group). Social structure is the abstraction made to encompass the patterned relationships among people in their social life (their role-relationships, systems of authority, and decision-making, etc.). Culture and social structure are interpenetrating abstractions, and for many purposes can be referred to jointly as the sociocultural system. For some purposes, however, the distinction may be very useful to make. In relating culture to mental disorder, for example, one would feel certain characteristics of cultural systems (e.g., conflicts in values) as potentially causative of mental disturbances, whereas if one were relating social structure to mental disorders one might seek the high-risk points in certain roles (e.g., social roles that are subject to conflicting expectations, such as wives who have professional careers) more or less independently of cultural content.

How many anthropologists are there, and where do they work?

There are slightly more than three thousand associates of *Current Anthropology*, a recently innovated periodical, drawing on the participation of professional anthropologists in all fields throughout the world. In the United States, there are about one thousand Fellows of the American Anthropological Association. Social anthropology, within this, is a comparatively small field.

Most anthropologists work in universities. There are about one hundred and twenty institutions in the United States that offer a program of courses in anthropology (three hundred give at least one course, often taught by a nonprofessional). About fifty universities have independent departments of anthropology, and about forty have anthropology departments combined with sociology.

Social anthropology, unlike other branches of the field, does not publish a separate journal, although the journal, *Ethnology*, comes close to focusing on the field we have in mind. Professional writings in the field of social anthropology and mental health can be found in *Human Organization*, the journal of the Society of Applied Anthropology; in *Behavioral Science*; in the sociological and psychological journals; and in the journal for social scientists in medicine, *Health and Human Behavior*.

What distinguishes the anthropological approach to problems of mental health from the approaches of other social sciences?

The anthropological approach tends to be more holistic than those of its social science sister fields (i.e., it seeks to interrelate all aspects

of the social and personal situation, and to relate sociocultural phenomena to linguistic, historical, and biological data as well as the narrower spheres of interest usually demarcated by sociologists).

Its approach is usually observational. It asks, "What is going on here?" rather than, "What can I demonstrate about the relationship in this situation of certain variables I have conceptually abstracted and for which I have developed precise instruments of measurement?"

The participant-observer method is most characteristic of anthropologists, and they consider this indispensable for arriving at a true understanding of what they are studying.

The anthropologist's approach is also to be distinguished from that of academic psychologists and sociologists by the anthropologist's fascination with the irrational and nonrational aspects of social life. Experience with primitives, interest in religious, artistic, and other phenomena in cross-cultural perspectives have contributed to this viewpoint.

This combination of factors—holism, comparative case analysis, historical and environmental interests in the case, emphasis on the human instrument and on an understanding of other than surface and rational phenomena—has drawn anthropologists toward collaboration with the more dynamic psychiatrists, particularly psychoanalysts. Among the anthropologists who were actively involved with psychoanalysis from an early point in the development of the latter discipline were G. Róheim, George Devereux, Alfred Kroeber, and Clyde Kluckhohn. Subsequently, several active partnerships developed between anthropologists and psychoanalysts, yielding impressive contributions to the literature of both fields (e.g., Abram Kardiner's and Ralph Linton's cross-cultural studies of "basic personality" structure; Jurgen Ruesch's and Gregory Bateson's studies of communication; Marvin Opler's collaboration with Thomas C. Rennie and others on community studies; William Caudill's collaboration with Frederick C. Redlich and others on psychiatric hospital studies, and so on). (See *Communication and Mental Health; Personality; Psychoanalysis*)

What are the specific contributions of anthropology to mental health research?

In the largest sense, it may be said that the whole field of anthropology with its relativistic orientation has contributed to a general perspective—namely that the concept of mental health is not to be seen essentially as the absence of mental illness. The study of values and

life in various cultural groups around the world shows that people can be mentally healthy or unhealthy in a variety of ways. Persons whose behavior would be termed mentally ill in our own society may under some circumstances be considered normal or even to have special gifts in other societies (e.g., shamans going into trance states in the course of religious or curing ceremonies). Behavior considered mentally healthy in our own society might be considered abnormal in other societies (e.g., the punishment of children by beating them for misbehavior). Furthermore, there are some kinds of disorders reported in other societies that may or may not be manifestations of essentially the same functional disorders known in our society, e.g., the occurrence of "amok" in Malaya, "arctic hysteria" in the northern regions, "wiitiko" (windigo) among the Ojibwa, "frenzy hysteria" in Africa, "koro" in China, and so on.

For many years, and in a great variety of contexts, Margaret Mead, perhaps the leading figure among contemporary anthropologists active in the mental health field, has tracked down and explored various dimensions of the nexus between culture and mental health and mental illness.

An outstanding contribution through the joint approaches of anthropology and community psychiatry is by Alexander Leighton, a psychiatrist with extensive fieldwork experience in anthropology. In his "Stirling County Study," he demonstrated a correlation between prevalence of mental disorder and condition of disorganization in the social environment. The approach to the epidemiology of mental disorder that is distinctively anthropological is that whole communities are studied in order to compare their entire yield of mental disorders, explaining the differences in terms of qualities of the communities themselves. The alternative approach, probably more favored in other disciplines, would be to choose particular situations that are hypothesized to be fraught with psychological hazard, e.g., the role of foreman in an industrial plant, the responses of individuals to disaster, etc.

Modern work in this field has developed along several lines. Gregory Bateson, an anthropologist interested in communications theory, has collaborated with Don D. Jackson, a psychiatrist, and others to develop a theory of family relations in which the "double bind" pattern of communication is postulated to be intimately associated with the development of schizophrenia. Siegfried Nadel, a British social anthropologist, produced evidence from his African studies that Nuba hill tribes, in which there were an ordered sequence of *rites de passage* in adoles-

cence and early marriage, had a more positive, optimistic view of life than did similar tribes in which these rites were lacking. John Whiting has indicated, through his cross-cultural studies, that the presence or absence of some of these *rites de passage* (e.g., male initiation rites in adolescence) is associated with the sleeping arrangements of the family. Where the children are very intimately and exclusively exposed to the female for long periods of time (e.g., through polygamy or long post-partum sexual relations taboos), there is a strong female identification developed, which may be counteracted through such rituals or made itself felt in other ways, presumably with deleterious mental health consequences in some cases.

Another area in which anthropologists have been active has focused on therapeutics. Studies of the lives of "primitive" curers and the social dynamics of their therapeutic séances have deepened our understanding of psychotherapy (for example, the work of Alexander Leighton on the Navaho, George Devereux on the Mohave, Morris Opler on the Apache, Morris D. Carstairs and William Caudill on India and Japan).

In our own society anthropologists like Caudill, Jules Henry, and Robert Rapoport have studied the functioning of psychiatric hospitals, seen as small societies, in order to illuminate the characteristics of the social environment that might contribute to or detract from the effort to help patients to be mentally healthier. (See *The Therapeutic Community*) Ozzie Simmons and David Landy have studied some of the problems of making the transition from the psychiatric institution into the larger society, particularly into different family structures. Married ex-patients face challenges in the form of the familial role-expectation that are more exacting than those faced by single ex-patients. This may be faced as a challenge and yield improved mental health, or be experienced as stressful and result in rehospitalization. Marvin Opler has indicated some of the ethnic subcultural differences among American urban families that affect both etiology and therapy. Similar stresses of life tend to be reacted to among the Irish by drinking and among the Italians by more antisocial "acting-out." Another kind of insight comes through the detailed study of how alien cultures are changing. The stresses and strains entailed in change are important factors in mental health. The study of how people undergoing change cope with the introduction of new institutions from Western society may contribute valuable principles for social and preventive psychiatry (for example, the works of Oscar Lewis, Benjamin Paul, George Foster, and John Adair). (See *Social Change and Mental Health*)

How may culture affect individuals' vulnerability to a mental illness?

Through providing for individuals with patterned sets of child rearing experiences, patterned values of life, patterned types of living arrangements, work activities, and so on, cultures mold what Kardiner and Linton referred to as "basic personality structures" of social groups. These "modal" or basic traits of character found widespread in the culture can be traced to early childhood experiences and later supportive patterns in the culture as illustrated in Ruth Benedict's *Patterns of Culture*. Some such basic personality patterns can be seen to resemble, superficially at least, patterns well known to psychiatrists as indicative of mental ill health when found in persons presenting themselves in a "Western" clinic. There are too few careful studies of actual distributions of psychopathology in different cultures to offer more than suggestive impressions on the topic of the relation between the basic personality pattern prevalent in a society and the type and prevalence of mental illness to be found in the society. One study by Seymour Parker may be mentioned because of its detailed attempt to relate child rearing experiences to the special form of cannibalistic psychosis, wiitiko, found among the Ojibwa. He would see the disorder as stemming from early oral deprivations rather than from severity of the environment per se. (See *Culture and Personality*)

Other ways in which a culture may affect the vulnerability of a person to mental illness may be through its mechanisms of preferential mating (and thus its patterning of genetic inheritance) and its habits of work and values associated with work. (In cultures where there is solitary activity under severe environmental exposure, as in many of the Arctic area cultures, one would expect different patterns of breakdown than in cultures where work is in groups, close to home, and less trying physically.)

Culture also figures into the patterning of individual vulnerabilities in more indirect ways. One way is through its provision for the handling of unusual situations, i.e., situations for which there are no predetermined solutions, like disasters, forced migrations, rapid technological or sociocultural changes, epidemics, etc. Cultures vary in the degree to which they provide effective patterns that would assist in coping with novel situations. (See *Stress*)

It would seem, then, that individuals may be rendered vulnerable to disturbance, either through "normal" experiences in a sociocultural system where defects and stresses are built into the prevailing patterns,

or through participation in unusual, deviant, or marginal types of experience for their society.

Can culture affect the actual form of disorders?

In addition to creating characteristic stresses that make individuals more vulnerable, cultures seem to contribute to the actual form and content of the disorders in several ways.

Cultures and societies seem to affect the form of the symptomatology in terms of the ideas they sustain about what disordered behavior looks like (in effect defining unusual social roles into which disturbed persons can fit, comparable to the more usual ones like husband, chief, etc.). They also seem to mold the form taken by disorders in terms of more generally present ideas and attitudes that may under some circumstances become activated. The presence of messianic beliefs may, under some circumstances, allow a deranged individual to be accepted as a messiah; the presence of witchcraft beliefs may lead to this definition for some individuals who in other societies might be differently labeled, or differently related to, and who would consequently react differently and possibly be differently disposed of.

Do different cultures provide different forms of therapy for disordered persons?

Considering only the cases where the disordered person is allowed to live within the society and chooses to continue living, it is apparent that a wide range of practices considered to be therapeutic have come into being. In some societies, for example, socially acceptable or at least tolerated havens are provided for those who cannot cope or who prefer deviant patterns of behavior (e.g., the bohemians, the "berdache" as an institutionally acceptable homosexuality role, the apocalyptic or expressive religious sects manifesting unusual beliefs and behavior), while in other societies (e.g., some of the Pueblo Indians of the American Southwest) the range of acceptable deviation is very low. In this sense, tolerance may be thought of as a form of therapeutics, in that it does not evoke the kinds of negative sanctions for variant and deviant behavior that might exacerbate the individual's disturbance.

Looking at therapy as a more active form of social control mechanism, implicitly or explicitly geared to reinstating deviant individuals to the mainstream of society, Anthony Wallace has noted two broad types of strategies that seem to be employed—one emphasizing controls and disciplines, and the other emphasizing "catharsis" and the expres-

sion of pent-up emotions. The former, seen for example in the Iroquoian revitalization religion known as the "Handsome Lake Movement," was noted to have gained ascendancy at a time of relative social change and disorganization, when personal disturbances threatened to disrupt the very fabric of social order; the latter seem characteristic of stable periods of social organization in which the pressures of conformity are met at the cost of a certain accumulation of emotional energy that has to be discharged periodically if conformity is to continue. Max Gluckman has described some cathartic devices as "rituals of rebellion," in noting that a society gains rather than loses in solidarity and support of its fundamental institutions if it allows occasional patterned expressions of negative feelings toward high status role incumbents.

Several observers of primitive healing practices—Morris Opler, Leighton, Devereux, etc.—have noted the effective use, under religious or other rationales, of principles now explicitly recognized as part of scientific psychotherapy. The judicious use of cathartic and control strategies are among these, but also included are the interpretation of dreams, the use of supportive group meetings, hypnotic and other suggestive devices, etc. In addition, Western pharmacopoeia is continually being enriched by increments from the empirical traditions of folk medicine, many of which (like peyote) are relevant to mental health.

What use can the results of anthropological studies be put to in the mental health field?

The application of anthropological findings to the practical work of promoting better mental health has been made through several channels. Ranging from the most "disengaged" channel to the most "engaged" channel, one notes at one extreme that anthropological publications are made available to the layman and professional public via the mass media of communication. Several anthropologists have expressed an interest in reaching such a public by dedicating their works to the efforts of the World Mental Health Year (1961). Margaret Mead, among others, has been very active in opening channels of communication between anthropologists and members of the health professions via the agencies of U.N. E.S.C.O. and the World Federation for Mental Health. Some anthropologists are on the staffs of medical schools, teaching hospitals, psychiatric clinics, and even state and local health departments. Their work ranges from the teaching of students, interns, and residents, to the conducting of research programs with

varying degrees of tight-knit collaboration with their health colleagues.

Perhaps the most tight-knit form of engagement of anthropologists in the promotion of mental health can be seen in the kind of work called "action research." This procedure involves close collaboration—between the research anthropologist and his action colleague in the mental health field—to bring to bear findings and theories of anthropology to evaluate and experimentally modify an existing mental health practice. Particular promise for collaborative action research is seen in the fields of community mental health and sociocultural change in "underdeveloped" areas of the world as well as in the more conventional areas of ethnology, epidemiology, and the study of therapeutic practice.

SOCIAL CHANGE AND MENTAL HEALTH

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When we speak of social change as related to mental health, we refer in fact to changes in the spheres of technology, economics, and cultural life that influence the personality development and the behavior of man in one way or another. Technological advance is, of course, the main cause of industrialization; however, it modifies not only the production process and the supply of goods but also the conditions of transport and the speed of international communications. New developments in the field of economics (monetary instead of barter economy, rise of acquisitive value of the average income, increase of availability of goods, intensification of sales pressure, etc.) very often interfere with existing patterns of need-satisfaction, for instance, by modifying established need-priorities or by creating completely new (physiological or psychological) needs. Cultural change nearly always corresponds, at least in our times, to a process of "secularization," that is, to the more or less abrupt replacement of traditional values or value systems by new and more "rational" ones.

But social change is not the only term that is hard to define. It is just as difficult to say, in precise terms, what should be understood by "mental health." Some years ago, I pointed out that "the behavior of a mentally healthy person is always characterized by the qualities of reasonableness and balance," and that a sensible measure of a person's mental health might be the degree of his ability "to satisfy in a reasonable and balanced manner all his needs, both the instinctual and those that belong to the field of values." I believe this conception to be reasonably free of cultural bias and therefore consider it particularly appropriate for use in this article.

Obviously, social change can influence the mental state of man in more than one way. First, it should be pointed out that social change by no means always has a deleterious influence on mental health, but is,

on the contrary, sometimes likely to improve it. Furthermore, it should be noted that social change acts on the mind not only psychologically, but, to quite an extent, also through physiological mechanisms.

Concerning the positive effects of social change, we might remember that the so-called industrial revolution has certainly done a great deal to make people's minds healthier. It is, indeed, undeniable that the facilitation of communications and the better provision of material and cultural goods have enhanced the restrained personality development of innumerable millions.

As to the physical influences on mental health (through socially determined changes in the field of somatic health) it would be easy to give several pages of details. Here it may suffice to point out that the eradication of malaria and ancylostomiasis (hookworms) or the improvement of inadequate nutritional conditions will go a long way toward preventing mind-crippling physical weakness or brain disease, while on the other hand, the spread of syphilis and the readier availability of cheap alcohol cannot but inflict the most serious damage on the brains of a population.

It is a fact, however, that when the subject of "social change and mental health" is under discussion, what is meant is usually the deleterious influence of social change through psychologically meaningful events. Accordingly, in the following we shall concentrate on this aspect of the problem, beginning with an appraisal of its importance, then examining the decisive factors in the psychosociogenesis of mental ill health, and after that the genesis and structure of the disorders in question, and studying finally the measures that can be taken to counteract the undesirable influences of social change.

The relative importance of this category of mental disorders is viewed quite skeptically by some authors. Their attitude is probably justified with regard to the major psychoses. An American study of 1949, *Psychosis and Civilization*, by H. Goldhamer and A. Marshall, shows indeed that between 1845 and 1945 there was no significant increase in the admission rates of a mental hospital in New England. It is true that this result is to a certain extent contradicted by that of an earlier German investigation that was based on painstaking population censuses carried out in a certain region in 1804 and in 1908. The prevalence found was, however, not very much higher in 1908 than in 1804, and if we compare the incidence of insanity proper in "developed" and "developing" countries, we are led to conclude that social change is

much more likely to modify the clinical manifestations than the frequency of the major psychoses.

The situation is quite different with regard to the psychoneuroses, sociopathic disorders, and psychosomatic troubles. Statistical evidence indicates that these disorders are considerably more frequent in "developed" areas. It is a fact, moreover, that in countries undergoing rapid social change psychiatrists and nonpsychiatrists alike complain about an increase in frequency of alarming proportions and terrifying speed. An interesting discussion on this point can be found in *Mental Health and the World Community*, published by the World Federation for Mental Health. Some authors pretend that it is not mental disorder itself that makes its appearance with social change, but that there is only a heightened awareness of it in changed economic and cultural circumstances. This argument is, however, exceedingly weak, since disease is never an entirely biological reality and social factors always play a major role, especially where mental disorders are concerned. To illustrate: an area can be flooded because the rivers have swollen or because the ground has subsided, but what counts is that a flood surely has occurred and that there are victims who require help quite irrespective of the ultimate cause of the disaster.

As to the factors that have to be taken into account when we study the effects of social change on mental health, there are two series that must be considered. First, there are social changes that are more likely than others to produce mental disorders, and second, there are populations that are more easily affected than others by social changes.

Social change is apparently particularly pathogenic when it is revolutionary, that is when it has some magnitude and takes place with some suddenness. It is not easy, of course, to say how big and how sudden a change has to be in order to qualify as a revolutionary event. As it is, there are authors (mostly technicians and economists) who consider it unjustified to refer to the technological and economic upheaval of the last 150 years as an "industrial revolution."

The reasoning of these skeptics is that the differences between various stages of technological development were so small that none can be considered to have been fundamental, and that the transitions between them were so gradual that no change could be called abrupt. This may be right from the point of view of technology and economics, but it is certainly not true in the perspective of psychology and psychopathology. A change that objectively may seem to be trivial is often very important from the subjective point of view; for example, the inhabitants of an

upper-class apartment house will experience the conversion of even one apartment into a multiple-family unit as a most significant symptom of "lost status." Similarly a change of conditions, though objectively slow, can have a subjective character of suddenness if—perhaps precisely on account of its slowness—immediate perception is delayed; e.g., an inhabitant of the apartment house may not notice that it is slowly falling into disrepair until a flake of plaster falls from the dining-room ceiling into his soup. (See *Social Status and Mental Health*)

Concerning populations' different susceptibilities to the stresses of social change, it should first of all be emphasized that this is a relative, not an absolute, matter. There is no "natural immunity" to psychical traumatism, and the psychosociogenesis of mental disorder is nowhere a thing of the past.

It is true that in the "emerging countries" of our time the pace of development has become so accelerated that the danger of "mental ill health through social change" is particularly great. There is, moreover, the fact that in most developing countries industrialization is likely to be accompanied by the introduction of new and essentially foreign cultural patterns that, of course, reinforce the pathogenic potential of the technological and economical changes. In the emerging countries of Africa, for instance, it is a typical experience that newly recruited industrial workers very quickly acquire the tastes and habits of the city people, and at the same time dissociate themselves from the "old-fashioned" ideas and customs of the "bush." It should not be forgotten, however, that the so-called developed world has by no means stopped developing, but that it is, on the contrary, capable of very important and very sudden changes. In the same context, it should be remembered that psychologically and psychopathologically there would not seem to be a fundamental difference between the smashing of the first machines by the Luddite rioters in Nottingham, England, in 1806, and the Standard Motor workers' panic reaction to automation in Coventry, in 1956.

Concerning the genesis and structure of the disorders that we believe to be psychological responses to social change, it can be said that, generally speaking, social change acts as a stress-producing factor and, like any other "stressor," therefore provokes phenomena of shock and countershock, that is, in psychological terms, anxiety and defense reactions. Where a development is seen to provoke abnormal reactions, it does so because it is experienced as a menace to physical or mental

stability. In this respect we may refer to the excessive widening of physical or mental horizons (by sharply increased mobility), threats to security with regard to physical or psychical needs (through loss of income or status), and the abrupt liberation from hierarchical controls (by sudden loosening of family ties or disruption of traditional loyalties). But the predisposition to shock is perhaps even more important. Events are indeed much more anxiety producing when the person is somatically or mentally unstable, weakened by malnutrition or chronic disease, or sensitized by traumatic experiences in infancy.

There is, of course, some discussion as to whether psychoanalytic theory is right in attributing so much importance to childhood happenings, even in respect of sociogenic psychopathology. Indeed, there are many who hold that the predominant role in the production of mental stress by social change corresponds to traumatic events in the "here and now." It seems hardly necessary, however, to discuss this issue in detail, since it is obvious that both interpretations must be taken into account not only as competing, but also as cooperating factors.

It is perhaps useful to point out that the psychoanalytic conception is strongly supported by the universal experience that mental disorder of psychosocial origin has a tendency to snowball from generation to generation, an event that doubtless is most easily explained if one assumes that parental neuroses and behavior disorders exercise a powerful pathogenic influence on the growing minds of children. In view of this phenomenon it has sometimes been said that the incubation period of psychogenic troubles in the individual is twenty years, but that in societies it amounts to three generations. This formula may be too epigrammatic to be quite accurate, but it cannot be denied that it contains a grain of truth. Another fact that proves the great importance of the "social climate" in childhood is the high incidence of mental disturbances in societies where family life has become disorganized, as shown in A. H. Leighton's *My Name is Legion* and Charles C. Hughes's *People of Cove and Woodlot*, and in individuals who have grown up in permanently or temporarily incomplete or disturbed families, as pointed out in John Bowlby's *Maternal Care and Mental Health*.

It stands to reason that disorders that are psychological reactions to social change are particularly amenable to social therapy. The remarkable results that can be obtained in the treatment of sociogenic behavior disorders in "therapeutic communities" are a case in point. An in-

interesting description of "therapeutic communities" can be found in Maxwell Jones's *The Therapeutic Community*. (See also *Controls from Within* by Fritz Redl and David Wineman.) But also, persons with psychoneuroses and psychosomatoses often benefit from being given "opportunities for making contacts with society favorable to the . . . reestablishment of social adequacy." Clearly it would not be possible to give a useful description of social psychiatric techniques in a few words. At best one might say that the basic idea is to organize the social environment of the patient in such a way that even very pathological behavior patterns can be tolerated, while at the same time the patient can gain a certain insight into the possibility of reacting to psychological stress in a socially more acceptable way. If this learning process continues long enough, the patient has a good chance of healthily adapting to ordinary social environments.

Prevention is surely more important still, but it must be recognized that it is at the same time exceedingly difficult to organize.

To begin with, the fact has to be faced that social change cannot be stopped, let alone reversed. There is no way of preventing science and technology from constantly inventing new ways of facilitating production and speeding up communications. Nor can we expect to modify an economic development that is largely determined by explosive population growth. According to the *United Nations Population Bulletin* of December 1951, the total estimated population of the world amounted to 470,000,000 in 1650, 694,000,000 in 1750, 940,000,000 in 1850, 1,950,000,000 in 1900, and 2,510,000,000 in 1950. Data contained in the *United Nations Demographic Year Book* for 1961 indicate that in 1960 the number had grown to 2,995,000,000.

It should be added that the sharpest increase took place in the developing areas of the world, i.e., in the regions where the pace of social change is particularly accelerated and therefore pathogenic. Nor is there any likelihood that traditional cultures will be able to maintain historical systems of behavior while ships and airplanes, motion pictures and television programs, as well as magazines and newspapers, are competing in constantly creating new images likely to turn into new cultural ideals.

But if we cannot avoid the violent impact of social change, we can certainly render it less harmful and traumatic. For instance, it is quite often possible to prevent a too intense and too sudden widening of the physical and mental horizons. If industrialization is inevitable, the

same cannot be said of urbanization: there is no reason why light industries could not be located in rural areas, thus providing a potentially migratory population with the benefits of industrial production without exposing them too much to its bad influences. The provocation of anxiety by a menace to the security of job and status can be prevented, or at least very much diminished, by timely information about the probable consequences of impending changes. When, in Margaret Mead's words in *Cultural Patterns and Technical Change*, it is feasible to ensure "the fullest possible consent and participation of those whose daily lives will be affected," the tolerance threshold is very often found to be surprisingly high. In order to avoid the dangerous breaking up of traditional hierarchical controls, it is of prime importance to give an appropriate "education" to community leaders, religious leaders, teachers, and particularly to parents. Apart from this, it will often be advisable to give those in authority some sort of proper psychiatric help (for instance, a modified form of group treatment) in order to allay their fears of losing their influence because they are old-fashioned and outdated.

The strengthening of those who are exposed to the stresses of social change is, of course, at least as important as the buffering of stimuli. We have already pointed out that good physical health will go a long way toward making a person resistant to psychological stress. The most important measures, however, are those that in one way or another belong in the field of education. Here again is occasion to stress the outstanding importance of family relationships. A person who during childhood enjoys a reasonable amount of emotional security and thereby acquires confidence in himself and others will often be able to stand up to the threats of social change without excessive anxiety and pathological defense reactions.

But as has been said previously, later influences should not be underestimated. Many people whose infancy has been emotionally insecure, and who during childhood could not gain confidence either in themselves or in others, are able to make up for this lack through satisfactory professional and social contacts during adolescence and early adulthood. What is usually called ego strength depends to a large extent on the person's ability to establish a secure identity. While this identity is perhaps not exclusively gained by the process of identification with others, the personal and cultural environment of man is certainly of the highest significance for the development of his ego structure. In this

connection, the psychological climate of the social environment is indeed exceedingly important at all times, and this is a point that should be strongly underlined, since it is fundamental for a better understanding of everybody's unavoidable responsibility for the state of mental health in the world. (See *World Mental Health*)

SOCIAL FACTORS IN MENTAL ILLNESS

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Mental illness entails disordered processes of thought and emotional expression, but it is recognized and responded to primarily in terms of disrupted social relationships. Our knowledge of the role of social factors in the causation of mental illness is still meager and lacking in precision. In part, the inadequacies of our knowledge are related to problems of measurement—accurate measurement of the incidence of mental illness and accurate measurement of the significant dimensions of social experience. Although theories of the importance of social factors in mental illness go back to antiquity, attempts to test such theories through systematic research are only a few decades old. But this is only part of the problem. Another part derives from the fact that the meaning of any given social factor or experience depends upon the larger social and cultural context in which that factor is found. Therefore, no single study or series of studies is sufficient to establish the generality of a relationship between a given aspect of social life and mental illness.

SOCIOECONOMIC LEVEL AND SCHIZOPHRENIA—AN EXAMPLE OF A COMPLEX RELATIONSHIP BETWEEN SOCIAL FACTORS AND MENTAL ILLNESS

Let us take an example. One of the most influential studies done of the social correlates of mental illness was *Mental Disorders in Urban Areas*, by Robert E. L. Faris and H. Warren Dunham. This demonstrated that the rate of patients admitted to a mental hospital for the first time from various areas of the city of Chicago showed a clear pattern of distribution, with the highest rates concentrated around the central business district and the lowest rates in areas on the periphery of the city. Faris and Dunham further demonstrated that rates of schizophrenia were highest in areas of lowest socioeconomic status. More recently, August Hollingshead and Frederick C. Redlich have shown that for the city of New Haven the rate of persons hospitalized or in

outpatient treatment for schizophrenia as of a given date is approximately eight times higher in the lowest social class (lowest one-fifth classified on the basis of education, occupation, and residence) than in the upper middle class (upper tenth).

Other studies of the incidence of schizophrenia by social status or occupational groups in the United States and Great Britain have in general shown the same pattern. But there are exceptions. Socioeconomic status does not appear to be related to the rate of hospitalization for schizophrenia in at least one small American city, in areas of the city of London, and in studies in Norway. Thus, in such research one must examine the meaning of a given social factor—social class, migration, social change—in the context in which it appears. Moreover, this must be done in at least two senses: (1) to ascertain the extent to which this factor may be linked in a meaningful way to a significant theory of causation (for example, a theory of the psychological effects of low social status), and (2) to ascertain possible relationships between the factor in question and the way in which mental illness is perceived and dealt with (for example, the possibility that social status is associated with tolerance of deviance and that lower-status schizophrenics may not be hospitalized as readily as are those of higher status).

SOCIAL FACTORS IN PERSONALITY DEVELOPMENT

The personality is itself a social product, or, more properly, a product of the interaction between the constitutionally given potentialities of the organism and the social and cultural environment in which the child learns gradually the behaviors, attitudes, and social skills appropriate to an adult member of the society. We need not elaborate upon this most crucial influence of the social environment upon mental health in the present article, since it has been treated in detail in other articles in this encyclopedia. Suffice it to say that the stability of relationships within the home during the early years of childhood, and the provision of warm nurturance by a mother or mother-substitute, appear to be positively related to subsequent mental health. Both of these conditions are themselves influenced by position within the social system. The family tends to be least stable at the lowest levels of the socioeconomic order and, perhaps as a consequence of the greater burdens entailed in motherhood, there is some evidence that maternal warmth is more often lacking in the lower-status mother.

But social status—position in the community—is not the only significant social influence on psychological development. The nature and

level of expectations a parent has, relative to the child's abilities and the expectations held for his peers, can become a major source of vulnerability in personality development. For the child often comes to take over his parents' expectations, even when they are impossibly high. More generally, the agreement or conflict between the standards given the child in the family (moral precepts, attitudes toward others, life goals) and those of the larger society will influence the child's patterns of association, the coherence of his self-image, and the ways in which he ultimately carries out his adult roles. Gross conflicts of values and standards need not lead to mental illness but are likely to lead to rebelliousness or alienation in many instances. These, then, are illustrative of the ways in which early social influences may lead to vulnerabilities or potential sources of later trouble.

SOCIAL STRESS AND MENTAL DISORDER

It is difficult to make a clear separation between sources of vulnerability and sources of stress, because the former very frequently give rise to unpleasant tensions long before a major crisis occurs. But we may distinguish between relatively early influences that leave a person with a degree of psychological impairment (for example, insecurity in intimate relationships deriving from disruptions or trauma in early family life), and the effects of pressures or stresses with which a person must cope. The latter may be encountered through migration, entry into the armed forces, parenthood, the demands of a new position, loss of a loved one, failure to achieve a cherished goal, and similar life experiences. We have only meager information about the influence of such stresses on different types of people. It appears that migration is often accompanied by a higher than average expectancy of mental disorder (See *Mobility and Mental Health*), but much depends on the reason for migration and the characteristics of the persons involved. Entry into the armed forces, at least for males in the United States, appears to precipitate a considerably higher rate of psychotic breakdown than is found for the same age-group in the population at large. On the other hand, the stresses of war, including the bombing of civilian populations during World War II, seem in general to have been accompanied by a decrease rather than an increase in psychotic breakdowns in the countries of northwestern Europe.

Aside from situations in which continuing physical strain and extreme personal danger are involved, it appears that the psychological stressfulness of any situation depends largely upon the meaning that it

derives from the individual's life history. To the extent that any given situation or event is a threat to a person's image of himself or to the values that he has incorporated in his personality, it is likely to be experienced as stressful. Perhaps this is why war and mass catastrophes do not appear to be as traumatic *per se* to mental health as do instances of personal failure that may lead to feelings of inadequacy and call for a reevaluation of who and what one is.

Whether or not the vulnerable person actually develops a form of mental illness or deviant behavior will depend upon the nature of the stresses to which he is subject and the resources available to help him over the critical periods of stress. And, similarly, whether or not any given stress or series of stressful experiences will lead to mental illness will depend on the nature and balance of the individual's vulnerabilities and resources. Moreover, there is reason to believe that the forms of mental illness manifesting themselves as a consequence of various stressful experiences will depend both on genetic and social or cultural factors. For example, there is evidence that a substantial degree of genetic vulnerability is involved in schizophrenia. Aberrant family patterns and deprived social status are also very frequently found as correlates of schizophrenia. It appears not unlikely that the psychological effects of these family patterns and of deprived social status will produce personalities with inadequate skills for coping with interpersonal problems, but that schizophrenia will in general not result unless the individual encounters stresses with which he cannot cope *and* is genetically vulnerable to schizophrenia. Lacking genetic vulnerability, the individual may develop a neurosis or a psychosomatic ailment, he may become withdrawn but not psychotic, or he may indulge in some form of deviant behavior.

THE NATURE OF SOCIAL AND CULTURAL INFLUENCES

To return to the more general problem of identifying the social factors that make for either vulnerability to, or the precipitation of, mental illness, we may note that the society and its culture (its way of life) channel the organism's primary needs into specific modes of demand and satisfaction, on the one hand, and provide the means and circumstances for such satisfaction, on the other. Thus the needs for food and drink are channeled by the culture into desires for specific dishes and beverages. Whether one craves tea, coffee, water, wine, or milk with one's meal or when one is thirsty is largely a matter of early experience. The person who is accustomed to one or two of these

beverages and is unable to obtain them when abroad may be acutely discomforted by this fact. In the same way, the person whose early experience has lead him to crave particular types of social response may be acutely disturbed if such response becomes unavailable. Similarly, a person whose society puts strong emphasis on the achievement of particular goals such as material well-being, and who lacks the opportunity to achieve such goals, may be markedly influenced in his feelings and behavior by this experience of deprivation. He may become alienated from the values of the larger society, he may pursue its goals through illegitimate activities, or he may develop self-disparaging and self-defeating attitudes.

SOCIAL DETERMINATION OF PATTERNS OF DEFENSE AND OF SYMPTOMS

One's society and, more specifically, one's place in society determine not only the goals sought and the opportunities for achieving them, but also characteristic ways of relating to others, of coping with problems, and even of defending oneself against anxiety and threats to self-esteem. Thus, an orientation toward purposive control of one's environment (as against more passive acceptance) is more characteristic of middle-class North Americans than of most people in simpler societies or, for that matter, than of North Americans who are of lower socioeconomic status. In the face of anxiety provoking stimuli, Daniel R. Miller and Guy E. Swanson have found that, middle-class persons more often use the defenses of "rationalization" and "intellectualization," while working-class persons more often use "projection" and "denial." (See *Mental Mechanisms*)

We do not have systematic data on the distribution of various types of psychological disturbance and mental illness other than psychosis, inasmuch as relatively few of the less severe mental disorders are ever diagnosed, but it appears that there is substantial variation both among societies and within complex societies. Whether or not they differ in number of persons with psychosis, it is likely that some societies, classes, or cultural groups produce many more of certain types of mental illness than do others; and there is clear evidence that the patterns of illness vary greatly from one group to another. For example, a study of the prevalence and types of mental illness among the Hutterites, a religious group living in South Dakota and Montana, found relatively few cases of schizophrenia or of bizarre, disorganized behavior, but a high proportion of cases of depression. The prevalence of depressive

reactions apparently mirrored the strict moral training and the high level of guilt feelings in this population.

The patterning of delusional symptoms in psychosis has also been shown to be significantly related to social and cultural emphasis. Thus, delusions of grandeur are found most often in the upper levels of social status while delusions of inferiority are found at the lower levels. Again, delusions of persecution are more often found among immigrants than among natives. In general, there seems to be a tendency toward fairly direct translation of social role and position into delusional terms.

SOCIAL ISOLATION AND MENTAL ILLNESS

Perhaps the most basic hypothesis about the relation of social experience to mental illness concerns the effects of social isolation. Man is by nature a social animal. The human infant is born into a family group that is itself part of a larger social organization. Not only through infancy and childhood but throughout life, most of us will never have experienced a period of even twenty-four hours in which we have had no contact with another human being. The self is a social product, a product of reflected appraisals. Without communication with others, the self tends to become disoriented unless the person has internalized goals and values that he can draw upon symbolically to sustain himself.

To maintain motivation and self-esteem, one must feel himself to be part of a group, accepted by his peers, able to count on their respect and support, and, hence, able to be comfortable in their presence. One is not, of course, always accepted in the varied groups that make up a complex society, and most people can tolerate the discomfort that comes from lack of acceptance in a group that is not particularly important to them. But when one experiences lack of acceptance in one's family, in one's basic peer group, or in any other group with which one would normally have prolonged, intimate relationships, acute personal distress is likely to result.

Sociologists have believed that isolation from normal peer relationships might be a significant factor in the development of schizophrenia. It was noted that many schizophrenics had not been participants in preadolescent and adolescent play groups. It was hypothesized that rejection by their peers led to their becoming isolated, withdrawn, and subsequently delusional. Recent research suggests, however, that the process more often begins with the experiencing of feelings of alienation. Once a person begins to withdraw and to fail to respond

to the overtures of others, a vicious circle of increasing isolation and further alienation tends to occur. Relationships with others become more stressful, leading to further withdrawal of the individual into his own "psychological shell."

While the etiology of schizophrenia is not to be explained in terms of social isolation, there can be little question that psychological ease and mental health require that one have a feeling of belonging to, and of acceptance by, a group of one's peers. The use of alcohol and narcotics frequently serve the purpose of facilitating such feelings of belonging. Experiencing real affiliation with others is more important than mere absence of isolation in the geographical sense or in the sense of number of social contacts. (See *Schizophrenia*)

SOCIAL DISORGANIZATION AND MENTAL ILLNESS

As previously noted, the personality consists in large part of an internalization of the attitudes, values, and ways of behaving that are characteristic in the segment of the society in which the person is reared. If he is subject to a consistent set of beliefs and behaviors and receives warmth and nurturance from others, he is likely to experience fewer conflicts and tensions than if he is reared in an environment in which divergent values and practices are warring for supremacy. The child torn between competing or conflicting parents cannot incorporate the beliefs of one without also experiencing, even if covertly, the negative feelings of the other.

In the period of heavy immigration to the United States, culture conflict—conflict between the Old World beliefs of the parent generation and the desires of their children to be "true Americans"—was frequently manifest both in the great amount of overt antagonism between the generations and in the delinquent and disturbed behavior of the second generation. Similar, if somewhat more subtle, conflict is still frequent as individuals raised in one segment of our pluralistic society (a society that offers many alternative possibilities rather than one coherent way of life) attempt to move into another segment.

Studies of the distribution of various social problems in contemporary society, such as crime, illegitimacy, and drug addiction, have consistently found that these problems are most prevalent in deteriorated areas of the community in which conventional social organization has broken down. The people living in such areas seldom completely disavow the standards of the larger society, but they lack confidence that these standards have any "payoff" value to them. Persons raised

in such environments are likely to be characterized either by lack of commitment to any coherent set of values or by frequently having conflicts about values. Many tend to have extreme problems with authority, to be unable to defer gratification of their impulses, and to seek outlets for their tensions either through "acting out" aggressively toward others, or by gambling and other escapist behavior. Psychological and psychiatric studies of such socially disorganized populations suggest that a wide variety of types of mental disorder are produced under such conditions, though only the most severely disturbed persons come into treatment.

SOCIAL RESPONSE TO MENTAL ILLNESS

A person may be mentally ill without anyone recognizing this fact. Indeed, research on the initial social response to psychotic mental illness has revealed that more often than not the symptoms of psychosis are seen as expressions of meanness, jealousy, weakness of character, or being upset, tired, or physically ill. In some societies, psychosis is regarded as an expression of possession by witches (or, as in the Bible, possession by the devil), in others, as a sign of divine revelation, in still others, as a sign of a failure to perform necessary rituals. This is not a trivial or merely interesting consideration. For the way the illness is defined and responded to can be an important determinant of the duration of acute disturbance, the degree of impairment of one's social functioning, and the effects of the illness on the life history. What the mentally ill person is called at any given time, what is expected of him before, during, and after the acute phase of his illness, and what is subsequently permitted to him will inevitably influence his conception of himself and his ability to handle himself with others.

Studies of mental patients in British communities with well-developed mental health services suggest that an early recognition of the person's need for help may avoid much of the "acting out" or bizarre behavior so frequently seen at the time of admission to a mental hospital in the United States. The person whose discomfort is *not* recognized and responded to tends to become more and more disturbed and to behave in ways that will force others to attend to him. Unsuccessful suicide attempts, for example, frequently symbolize the person's attempt to reestablish communication and elicit a compassionate response from others. In such instances, even when the person thinks he wants to kill himself, the methods employed and the circumstances are such that action by others can prevent tragedy. Anthropological studies

suggest that in smaller, simpler societies than our own, response to a markedly upset person is more immediate; frequently there will exist ritualized ways of relieving his distress and reincorporating him into the social fabric. In such instances, complete withdrawal is prevented and the illness does not result in the personal deterioration so often found in the long-term mental hospital patient in Western society.

We have already noted that social status, or more accurately, deprivation of status, may influence the incidence of mental illness, though the evidence is not entirely conclusive. There is, however, unequivocal evidence that social status influences the kind of treatment that one receives for mental illness (in the urban areas of the United States, at least) and the length of time that one remains in a mental hospital, once admitted. The research of Hollingshead, Redlich, and their associates in New Haven revealed that lower-status patients were far more often hospitalized and less often seen in clinics and other outpatient settings. Moreover, even when they were seen in psychiatric clinics, they were more often treated by junior staff members and received less treatment services than did upper-status patients. In the mental hospital, lower-status patients tended to receive "organic" treatments (shock, tranquilizers, etc.), while upper-status patients more often received psychotherapy. Upper-status patients tended to be released from the hospital after a much shorter stay than was typical of patients from lower-class backgrounds. It has not been established whether earlier release was primarily attributable to more effective treatment, to a less severe degree of illness in the first place, or to a general bias by middle-class psychiatrists in favor of middle- and upper-class patients. Several studies now in process should provide more adequate information on this topic.

THE STATUS OF THE FORMER PATIENT

Patients who make a successful recovery from a physical illness can frequently forget about the illness and can count on their associates to do the same. This is less true of mental illness. Despite increasing public information about mental illness, a stigma tends to attach to it. The former patient must learn to live with the fact that some of his associates may feel uncomfortable if they know about the illness. More important, the patient must come to terms with himself, must provide himself with an acceptable explanation of the nature of his previous difficulties and of the likelihood that he will be able to avoid

further difficulties. His ability to do this depends in large part on the responses of others toward him.

Recent research suggests that there are wide differences in the range of tolerance that former patients tend to receive in various living arrangements after hospitalization. Patients who return to live with husband or wife are, in general, expected to perform adequately their normal roles as adults—spouse, parent, worker, neighbor, and the like. Much less is expected of those who return to the household of their parents, even if they are adults. As a consequence, former patients living in these two settings show substantial differences in degree of impairment and in the likelihood of being returned to the hospital if they again become somewhat upset.

Some patients return from the mental hospital or emerge from outpatient treatment without any appreciable psychological impairment. They are effective, happy persons. Others show more or less marked impairment or unhappiness. Some have been, and remain, well integrated into a network of intimate relationships. Others have been, and continue to be, somewhat marginal in their social relationships. In general, it appears that severe mental illness leads to a constriction of relationships, both on the part of the patient's family and with reference to his own social participation. Thus, in all phases of the life cycle and in all phases of mental health and illness, there is a constant interplay between the behaving person—his thoughts and feelings—and the network of social relationships in which he seeks to achieve his purposes, in which he is defined and responded to by others, and, in the last analysis, in which he derives his life's meaning.

SOCIAL PSYCHOLOGY

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What is social psychology?

Social psychology is the field of inquiry that is concerned with the effects of the individual on social collectivities (groups of persons acting in concert or considered as a single unit), and the effects of social collectivities on the individual. Like psychology, sociology, and anthropology, it deals with all of human behavior. What makes it a distinct field of inquiry is not its data, but its perspective. Psychological theory is concerned with regularities in behavior from the vantage point of the individual—irrespective of the particular social environment in which he finds himself at any given moment. Sociological theory is concerned with regularities in behavior from the vantage point of social systems—irrespective of the particular individuals who may constitute the social system at any given moment. Social psychology is devoted to the interrelationships of the individual and the social system.

In practice, of course, many psychological studies do take account of the social context of individual behavior, and many sociological studies take account of the personalities of the people who make up a social system. But attention to social context is secondary to psychology's main interests, and attention to personality is secondary to sociology's main interests. Social psychology makes these secondary concerns of psychology and sociology its explicit focus of interest, and attempts to trace out systematically the manifold reciprocal influences of the social and the individual.

What are the origins of social psychology?

Although the problems with which social psychology deals have intrigued scholars for centuries, social psychology as a distinct field of inquiry is of recent origin. It was not until 1908 that textbooks devoted to social psychology were first published. By coincidence, two texts were published that year, one by a psychologist, the other by a sociologist. That social psychology stems from both psychology and sociology has been highly significant, not only for its birth, but also for

its development. In effect, there have been two parallel histories of social psychology: one is the story of psychologists who were dissatisfied with the lack of social perspective in psychological theory and research; the other, of sociologists who were dissatisfied with the lack of psychological perspective in sociological theory and research. Each group developed largely independently of the other, as a subspecialty of its own parent discipline. In recent years, however, the gap has been narrowing and, in addition, there has been a considerable infusion of anthropological thought.

Does social psychology have a characteristic way of explaining behavior?

Yes, although not all social psychologists would agree. To social psychologists, the key words for explaining human behavior are: status (a position in some social system), role (behavior characteristic of a given status), and situation (a series of interactions, located in time and space, and perceived by the participants as an event). This is not a complete list, but it illustrates some central aspects of social psychological perspectives on human behavior. Social psychological interpretations focus very decidedly on current circumstances and events. The past is important, for it is out of past experiences that people define present situations. But the emphasis is on the ways in which the individual's behavior is molded by the situations in which he presently finds himself, and his position in those situations.

Is there a basic conflict between social psychology and psychoanalysis?

There need not be, unless one were to take the extreme position that one or the other approach provided a complete understanding of human behavior. Rather, social psychology and psychoanalysis provide complementary perspectives, with the former emphasizing the individual's current social relationships and his place in the larger social network, and the latter emphasizing the beginnings of personality development in his relationships with his family.

Of course, there are many varieties of psychoanalytic thought. Most social psychologists would disagree with those analysts who base their interpretations on instinctual drives, or who underestimate the responsiveness of individual personality to social experiences beyond the earliest years of life. Between social psychology and those varieties of psychoanalytic theory that emphasize the continuing importance of interpersonal relationships, there is not even this degree of conflict. For

example, the theoretical perspective of Harry Stack Sullivan's interpersonal theory of psychiatry is indistinguishable from that of many social psychologists.

There is, nevertheless, a gulf between social psychologists and psychoanalysts—not because of basic theoretical disagreements, but because they tend to be interested in different concrete problems and to use quite different methods of inquiry. Social psychology developed in an academic tradition radically different from the clinical tradition of psychoanalysis. Its practitioners are not faced with the necessity of treating a human being in need; but they are faced with the necessity of posing their questions in testable form and of developing methods adequate for rigorous testing.

What are some of the principal problems with which social psychologists are concerned?

The variety of problems is immense. The *Handbook of Social Psychology*, for example, devotes chapters to each of the following problems: the social bases of motivation, the perception of personality, socialization of the child, psycholinguistics, humor and laughter, experimental studies of group problem solving, psychological aspects of social structure, the behavior of crowds, leadership, culture and behavior, national character, prejudice and ethnic relations, the mass media of communication, industrial social psychology, and the psychology of voting. This handbook, incidentally, provides an excellent review of the work of both psychological and sociological social psychologists, but it is distinctly oriented toward the former.

What methods do social psychologists use in their research?

Since the problems of social psychology are so various, its practitioners use a wide variety of methods which they share with the other social sciences. Many studies are based on data secured from interviews, which may range from the most standardized to the most exploratory. Other research relies primarily on observation of ongoing events. Here, too, a wide variety of particular techniques may be employed, from the use of one-way mirrors in experimentally contrived situations to recording by a "participant-observer" of events he has experienced as a member of some ongoing group or collectivity. Less well known, but often crucial, are methods for the quantitative analysis of documents, as in the analysis of mass media materials and historical records.

For any given study, the choice of method is largely dictated by the

problem itself. Nevertheless, the design of any particular study is likely to involve some degree of compromise, if only because of cost considerations; various social psychologists weigh the elements of choice differently. The experimentalists, in order to attain greater control over the relevant variables, pay the price of uncertainty as to whether or not one can generalize from the contrived social environment of the laboratory to the world outside. This is a price that sociological social psychologists are less likely to be willing to pay than are their psychological brethren, for their focus of attention is more likely to be social structure itself.

Sociological social psychologists tend to rely more heavily on research in natural situations, being more concerned that they deal with actually operating social variables, even at the cost of some indeterminacy as to whether or not other, unnoticed or unmeasured, variables enter into their results. Inasmuch as these unnoticed or unmeasured variables are often the personality variables that lie at the heart of the psychological social psychologist's interest, the latter is less likely to engage in this sort of research. Even in their use of the same basic technique, social psychologists vary as to which technical problems they deem most important. For example, sample surveys are used by both groups. The psychological social psychologists, however, are likely to pay more attention to the technical problems of measuring one or another dimension of personality, while the sociological social psychologists are likely to pay more attention to the problems of sample selection and securing accurate and comprehensive information about the larger social networks in which the individual is entwined.

What is the sample survey? What is its reliability? Its significance?

The best known of the research techniques employed by social psychologists is the sample survey. Its widespread use in the past two or three decades has been made possible by three important technical developments: statistical methods for the selection of relatively small samples from which one can generalize to larger populations with great confidence; methods of inquiry that make possible the reliable measurement of opinions, attitudes, values, and descriptions of behavior; and electronic data-processing equipment that makes possible rapid and accurate analysis of large bodies of data.

The sample survey can do much more than measure transitory opinions. Voting studies based on sample surveys, for example, have gone far beyond newspaper polls to tell us a great deal about the determi-

nants of voting choice. Other investigations have used sample surveys to obtain information on such things as: the influence of social class, ethnicity (race or nationality group), and religion upon parent-child relationships; the prevalence of mental disorders in various segments of the society; the determinants of occupational choice among college students; and the situational determinants of racial discrimination.

The most important limitation to the use of sample surveys for purposes other than the measurement of attitudes and opinions is that the information comes from an involved participant, rather than from a disinterested observer. Much has been done to overcome this limitation; for example, by designing survey questions to be as simply factual as possible, by the analysis of the internal consistency of interview reports, by subgroup comparisons that enable one to test the inferences drawn from larger, more general comparisons, and by the systematic comparison of several sources of information. Yet, without resorting to some outside criterion, one can never be sure that inferences drawn from interviews are valid. More and more attention is being paid to this problem.

In what ways is social psychology relevant to mental illness?

Social psychology contributes to the understanding of mental illness in two ways: through studies of normal personality development and normal human functioning basic to our understanding of abnormal or disordered personality development and functioning; and through studies of social factors in the development of illness, in the treatment of the mentally ill, and in rehabilitation. (See *Personality; Rehabilitation of the Mentally Ill; Social Factors in Mental Illness*)

From their experience in other research, social psychologists have given to these investigations a technical and methodological expertise. And from their awareness of normal variations from one segment of the society to another, they have been able to add a new perspective to the interpretation of the data. For example, they have shown that some patterns of family relationships believed to have been distinctive of schizophrenic patients are much more prevalent among normal families of the same social status than clinicians had realized.

The contribution of social psychologists to the study of the mental hospital has been to view the hospital from the perspective of other social institutions, and thus to help differentiate what is distinctive to an institution treating the mentally ill from what the hospital shares

*with other institutions. Much of what happens in the hospital, although seen by hospital personnel as therapy, is simply the management of a large number of people—and might be done better, and more therapeutically, if this were recognized. And much of what is directly attributed to specific therapies is accomplished more indirectly by the effect that these therapies have on the social organization of the hospital. For example, the tranquilizing drugs have, in many hospitals, so profoundly affected social relationships that even those patients who have not been given the drugs have benefited from the better social conditions of the hospital. (See *Mental Hospitals*)*

Is there any evidence that the individual's position in society has an appreciable effect on the likelihood of his becoming mentally ill?

Yes. It appears that the likelihood of becoming psychotic, especially of becoming schizophrenic, is greatest at the lowest socioeconomic levels of society. The evidence for this generalization is not conclusive, for the technical problems in measuring "the likelihood of becoming psychotic" in any segment of society are immense. Thus, studies based on rates of admission to mental hospitals fail to take account of all those persons (an unknown number) who, although ill, do not become hospitalized. Other studies that include not only patients admitted to mental hospitals, but also all psychotic patients seen by clinics, psychiatrists in private practice, social work agencies, etc., do better, but still leave out those persons who never seek treatment from recognized agencies. To ascertain how many people fall into this category, other studies have relied on sample surveys of the population. These, in turn, are plagued by two further problems.

One is the difficulty of accurate diagnosis—of determining, on the basis of a single interview, what is the degree of psychiatric impairment. The second is that from a sample survey one cannot tell how long people have been psychotic—which is a crucial matter, for two segments of the population may have equal likelihood of *becoming* mentally ill, but if members of the first *remain* ill longer, they will show up in greater numbers in a survey. In time, we shall be able to make repeated surveys of the same population, to ascertain which people have newly become ill. But before this is possible, we shall have to develop more reliable methods of diagnosis.

Meanwhile, no one study is definitive. But a number of studies, each with its own methodological shortcomings (but shortcomings that are different from those of other studies), point in the same direction:

a greater likelihood of becoming psychotic at lower socioeconomic levels. (See *Social Status and Mental Health*)

In what ways is social psychology relevant to mental health?

However mental health is defined—as the symptom-free, the normal, or the optimum functioning of the individual—we need to know how personality and behavior are influenced by the social world of which one is a part. This field of inquiry is central to social psychology's concerns.

Social psychologists have, by their research, thrown light on a multitude of problems central to the understanding of human functioning. They have shown, for example, that one's social class position affects a great deal of one's behavior: political preferences, consumption patterns, child rearing practices, levels of aspiration, memberships in organizations, performance on intelligence tests. In similar fashion, they have endeavored to trace the ramifications of such variables as race, ethnic background, and religion, for the individual's functioning. These are all broad-gauge analyses of the effects of social position upon individual functioning. Other studies have focused on the immediate social environment—the family, the work situation, the informal social group—to ascertain how these affect the individual.

Enough has been learned to demonstrate the very considerable importance of social structure—both the larger structure of social class, ethnic background, bureaucratic forms of economic organization, and the like, and the more immediate structure of family, friends, and work associations—for individual functioning. Far more remains to be done, however; social psychology has provided an array of facts about the importance of one or another aspect of social structure for individual functioning, but has not yet developed a comprehensive interpretation that fully utilizes these facts.

What might be predicted about the methods and scope of social psychology in the near future?

New methods will inevitably be developed to overcome the limitations of methods used in the past. Overreliance on the sample survey has brought widespread attention to the need for developing more systematic methods for the observation of ongoing events. The artificiality of much work in experimental social psychology has brought into focus the need for more realistic social experiments—and these are being developed. The parochialism involved in generalizing from studies

done in only one culture is being recognized, with the result that a great deal of work is now being devoted to developing methods for systematic cross-cultural comparative studies. Furthermore, there is increasing awareness of the limitations of relying too heavily on *any* one method; more and more, social psychologists are coming to validate inferences drawn, for example, from experimental studies, by means of studies based on participant observation and surveys, and vice versa. Finally, statistical models adequate for the type of analysis required in social psychological research—analysis involving the simultaneous consideration of many variables—are rapidly being developed.

It is harder to predict what will happen to the scope of social psychological research. Two strong trends are in evidence: one, toward even greater emphasis on important social problems—the effects of automation, international tension, desegregation—however inadequate present methods may be for studying such problems; the other, toward greater and greater precision in method and technique, frequently at the expense of the importance of the problem. This battle has raged for a long time in social psychology. An optimistic prediction is that methods are being improved so rapidly that the debate will soon become historical: that it is becoming increasingly possible for social psychologists to study the major problems of our time with methods and techniques that will satisfy the most rigorous.

SOCIAL STATUS AND MENTAL HEALTH

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What is social status? What determines status?

In every complex society, people tend to be ranked in a hierarchy of prestige. Social scientists use the term "social status" to designate position in the prestige hierarchy. For example, nearly every town of any size has its "first families" (perhaps referred to as the "upper crust" by those further down the ladder), its solid core of middle-class families, and at least a few "lower-class" families on whom the bulk of the population looks down.

The degree to which a society or community is stratified into status levels will vary somewhat from place to place and from time to time, as will the factors that determine a person's status as high or low. In general, though, we may say that in modern, industrial societies there are three or four primary determinants of status. Perhaps the most important is family background, which provides each individual with his initial social status. Linked with this, of course, are such factors as race or nationality, religion, length of time in the community, the occupational and educational attainments of one's forebears and parents, etc. Wealth may be an important part of the family heritage, but it will seldom be the primary determinant of one's social status in older, settled communities.

Beyond the social position of one's family, status tends to be determined by personal attainments, of which occupational and educational attainments are perhaps the most generally influential in contemporary Western society. Where one lives, one's patterns of association, one's style of life, all tend to influence position in the local prestige hierarchy, though of course these tend to be related both to family background and to occupational success.

Are there different kinds of status?

Although one finds general agreement in any community as to the nature of the status hierarchy or prestige ranking of individuals

and families, different groups will vary somewhat in their points of view as to what is most important in the ranking process. A college community may accord relatively higher status to an outstanding scholar, an industrial community to a captain of industry. During or just after a war, military leaders will tend to receive higher status ranking than at other times. Groupings within the larger society—organizations and institutions, for example—tend to have their own prestige hierarchies, which may or may not reflect ranking on the outside. In the typical American high school, for example, the star athlete and the glamorous, much-dated girl tend to be members of the leading crowd (higher status figures). Thus, there are different means by which status can be achieved in various groups, but within any given group, status means social position, however achieved.

Are race and religion related to status?

Any attribute of a person that leads to his being valued or devalued by others may affect his general social status. In a democratic society our ideal is that status differences will not grossly influence the opportunities by which people can utilize and be rewarded for their abilities and efforts. Anything that restricts opportunity—for example, the effects of prejudice—creates personal tensions within a democratic society. In a sense, all status distinctions that are not based on individual merit entail the possibility of prejudice, but it is those forms of prejudice that devalue group members on the basis of some stereotype of their inherent nature that are most damaging psychologically. Discrimination on the basis of race or religion, for example, represents a devaluing of minority groups and a restriction of the opportunities available to members of such groups. (See *Prejudice*)

How does status affect mental health?

As we shall see, there are a number of ways in which social status influences personality development and the feelings a person has about himself. (See *Personality*) Self-attitudes, especially the ability of the individual to accept himself for who and what he is, are an important aspect of mental health. But self-attitudes are formed by “internalizing” the responses of others, especially in childhood and adolescence; for example, the child who is devalued, looked down on by others, comes to devalue himself. This is probably the most important influ-

ence of social status on mental health. Inability to use one's capacities to attain socially valued goals, as a consequence of prejudice and the restrictive effects of certain status positions, is another. Inordinate concern with social status may itself be a significant personality defect and a threat to the mental health of one's spouse and children.

What are status symbols?

We have noted the importance of occupation, education, and family background (with attendant styles of living) as criteria of social status. Along with these go certain external trappings, visible symbols that one belongs or does not belong to the elite, the middle class, the working class. Included here are such things as the kind of car one drives, the neighborhood in which one buys a home, the clubs to which one belongs, whether one's wife wears Paris gowns or dresses from a mail-order house.

What functions do status symbols serve?

Status symbols serve to facilitate placement of people; they are in a sense badges of status. While they may in one sense help solidify social distinctions, they may also do the reverse. That is, insofar as the symbols may be acquired or achieved by persons of lower status, they become an aid to upward mobility in the status system. They may serve, then, to help a person validate his claim to higher status and provide him with a tangible feeling of belonging.

Preoccupation with status—compulsive striving to enhance one's prestige—can lead to the pursuit of status symbols for their own sake. Ultimately, if one puts social status above other values, such as friendship, personal integrity, and the ability to relax with others regardless of their social status, one loses perspective and balance. Often, of course, such compulsive striving for status is not so much a cause as a symptom of neurotic difficulties.

How flexible is the membership of social classes?

The social classes of the United States and, indeed, of most countries are not rigidly bound or defined. Some people are constantly moving up, others moving down, the ladder. Social scientists refer to such movement as social mobility. As a result of increasing educational

levels and the ever greater proportion of white-collar and professional jobs (coupled with a decline in jobs that entail manual labor), it is fair to say that there is a net movement up the ladder (i.e., there are fewer persons at the lowest levels). Any estimate of the amount of such movement depends on the structure of one's set of classes (i.e., how many rungs the ladder has and how far apart they are). It appears that about a fifth of all workers have moved appreciably up the occupational ladder relative to the jobs held by their fathers, while perhaps 5 or 6 per cent have moved down the ladder (in each instance crossing the boundary between white-collar and blue-collar or manual jobs) in the United States in recent decades.

Does the possibility of high status mobility create psychological problems?

Since earliest times in the United States, high valuation has attached both to equality of opportunity in the pursuit of a livelihood and to economic success as a means of status enhancement. The success story has been a major theme in our literature. "Every man a king," "every boy a potential president"—these were common expressions of the "American dream." The attainment of this dream, however, has not been equally available to all Americans. We recognize that opportunities are greatest for those who are already well up the status ladder. Increasingly in our technologically oriented society, success requires a high level of general education and of specialized training.

Despite efforts to provide financial aid for the college education of bright students from less advantaged backgrounds, such education still depends largely on family attitudes and income rather than on intellectual ability per se. In addition, as we have noted, some minority groups are denied substantial access to means of bettering their relative positions. Contemporary American society puts a very high value on occupational and monetary success but does not place equivalent emphasis on providing the means to achieve success. As a consequence, most children growing up in the socioeconomically deprived segments of the population must either pitch their aspirations low or encounter recurring frustrations as a result of the lack of opportunities available to them. Efforts to adapt to this discrepancy between goals and opportunities to achieve them produce a variety of behavioral outcomes and characteristic ways of seeking to attain and maintain self-respect. One result is a high incidence of various forms of deviant behavior, which

entail more potentialities for gain and less for loss to the lower status person than to those higher on the ladder.

In a society where there is less emphasis on improving one's position, the individual who is low on the prestige ladder is more likely to aspire to goals that are realistic for him. No society, however, even one based on a caste principle, is wholly rigid. It appears that the desire to improve one's lot characterizes most people in complex societies presenting wide variations in styles of life. The psychological consequences of status differentials are, nevertheless, much greater in a society that places high value on occupational success without providing equality of access to the means of achieving such success. We are accustomed to think that the United States affords greater possibilities for occupational mobility than do the older nations of Western Europe. In fact, however, several of them have been characterized in recent decades by a greater fluidity of the occupational structure than has the United States. Hence, it appears that psychological stress deriving from thwarted desires to enhance status is especially great in the United States. Our high rates of crime, drug addiction, and various other forms of deviant or pathological behavior appear to be attributable, at least in part, to this fact.

What effect can a parent's preoccupation with status have on the development of his children?

Children learn very early that their parents and other grown-ups make distinctions—often invidious comparisons—based on social status and status symbols. Parents preoccupied with status frequently will choose their children's playmates. Some neighbors are "like us" or "nice people"; others are "not nice." The Smiths may be characterized as "not bad sorts, but of course he's still driving that wreck of a Ford." It does not take long, then, for the children to learn to make status distinctions—and to discriminate accordingly. If these distinctions, as enforced or reinforced by the parents, unduly limit the circle of a child's friends and lead to his feeling that he is better than most of them, a dangerous alienation may result. By the time he is ready for school, he may be unduly concerned about conforming to his parents' expectations and quite unable to be comfortable with his classmates. Twinborn with the development of a contemptuous attitude toward some children is the realization that there are others who may look down on him; and it is precisely these children whom his parents want him to cultivate.

What problems can "keeping up with the Joneses" create?

The ideal of social equality, coupled with unparalleled opportunities for economic development and expansion in the United States, has, as we have noted, led to more rather than to less striving for status. In a rapidly growing, rapidly changing society, especially one in which wealth used for capital can be productive of tremendous power, money itself can become the prime status symbol. Spiritual, artistic, and human values tend to be sacrificed to the pursuit of wealth, not merely for the comforts and security it brings but as an end in itself. Thorstein Veblen, in his famous *Theory of the Leisure Class*, written in 1899, described some of the consequences of the pattern of "conspicuous consumption" or ostentatious spending by which status may be enhanced in societies where wealth is the measure of worth.

Are problems of status aggravated by advertising and the promotion of new consumer products?

To a high degree, modern advertising capitalizes on and seeks to accentuate patterns of conspicuous consumption. Unquestionably, this serves to reinforce the importance of money as a means to status, since it permits purchase of the trappings associated with high status in the promotional media. This emphasis is simply one aspect of the American status system, and illustrates the stress on goals rather than means. It must to some degree accentuate the tensions and feelings of status deprivation on the part of those who are subjected to the promotional efforts, but who cannot hope to own the products being promoted.

Are people today more concerned with status than were people in the past?

Population mobility, the diversity of interests and values in urban society, instability of the family, and extreme concern with material comforts and standard of living—these and other aspects of modern industrial society tend to be conducive of high concern with status. But it must not be thought that this is exclusively a modern problem. Molière's *Le Bourgeois Gentilhomme* was a model of status striving and, indeed, the literatures of East and West are filled with accounts of young men and women striving to climb the social ladder. Times of social change have been times of high social mobility. Unfortunately, we have little more than literary accounts to indicate the pervasiveness and psychological consequences of concern with status in other times. (See *Morals, Values, and Mental Health*)

What is a healthy attitude toward one's status? What is a healthy approach to changing it?

What one regards as a healthy attitude toward one's status will depend on one's perspective and the opportunities for doing something about status deprivation. It seems fair to say that one consequence of being at the bottom of the status hierarchy is a lack of knowledge about and of motivation toward the means of enhancing one's social status. On the other hand, those whose families have begun to move up are more likely to be strongly committed to improving their status, since this goal or value is most often learned about in the family. A healthy attitude toward status, as toward any aspect of self, entails a realistic appraisal of one's abilities and of the potentialities for their use.

The realities of the status system, including its rigidities and deprivational aspects for many groups, are not to be denied and are not readily to be changed. This does not mean that one must wholly "adjust" to or conform to the status quo. It does mean that one must take stock of assets and opportunities and especially that one must become aware of one's own status goals and the motives for seeking them. *

May preoccupation with status be a determinant of mental disorder?

Preoccupation with status is both a symptom of anxiety and low self-esteem and an attitude that tends to lead to more serious disorders. The person who constantly insists on deference from others is markedly handicapped in the give and take of social interaction. The person who claims a higher status than others accord him is the one whom others will most delight in discrediting. This appears to be an aspect in many instances of paranoid symptomatology. More commonly, however, status preoccupation is found in association with neurotically compulsive striving. There is also evidence that many families that have produced schizophrenic patients have been strongly status-minded, often setting goals that seemed hopelessly unattainable to the future patient. (See *Social Factors in Mental Illness*)

What treatments are available for persons who feel great anxiety about status?

Psychotherapy and, in many instances, group therapy appear to be the most promising means of treating status anxiety. In the group situation such anxiety is quickly manifest, but inasmuch as status outside the group has relatively little bearing on responses within the group, the person who is anxious about his status is constantly confronted by

evidence of the inappropriateness of viewing all relationships in terms of status. Much depends, however, on the specific nature and development of the individual's anxieties about status. For some patients, group therapy may be contraindicated. Therefore, a thorough psychiatric examination is desirable before making any commitments to a particular course of therapy.

Successful treatment depends on the ability of the patient to recognize that he needs help with this problem rather than to blame his problem on others and on the nature of the social milieu in which the patient lives. If the latter constantly entails his being devalued and humiliated, a change of situation may be even more important than treatment itself.

How important is status, for an individual's adjustment?

The importance of status derives from the fact that we build up our evaluations of self out of the evaluations received from others. Healthy "adjustment" is not so much conformity to social rules as ability to maintain respect for ourselves, to perceive reality correctly, and to be able to cope with our environment so as to achieve satisfying goals. The objective facts of status and the way in which these come to be defined by the individual will influence each of these aspects of mental health.

SOCIAL WORK AND MENTAL HEALTH

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What is social work?

Social work, depending upon who uses the term and in what kind of company, can and does mean a variety of things. The range of activities can include anything from the individually well-intentioned "Lady Bountiful," dispensing her largesse as whim or caprice moves her, to highly trained executives of multimillion-dollar organizations staffed by professionally trained people with highly developed technical skills. Indeed, in formal programs, tasks are assigned to volunteers who may appropriately refer to their activity as "doing social work." Thus, it is best to describe social work as a lay professional endeavor, depending upon who does it, where it takes place, and what it specifically involves.

Social work essentially finds its sponsorship as a lay endeavor. In the public field, through citizen interest, legislation is formulated and supported. Public agencies and programs bring into being social policy and action to implement services to individuals and groups. In the voluntary (private) agency field, the layman is usually seen in his participation in policy formulation on agency boards and community leadership. This reflects a cross section of participation and responsibility. In both fields the layman reflects and represents the taxpayer and contributor. He supports and interprets a program to the community at large. The services that all of these agencies offer to the public are administered by professionals with experience and training for their tasks. The agencies seek to translate the wishes of their sponsors into effective programs after having received approval. Here the professional, schooled systematically and disciplined with a sense of responsibility, practices his profession. At various levels of operation the professional analyzes the elements of the service that the agency offers to the public, delegates portions of the job to selected individuals, intro-

duces measures of evaluation, and is held to account by those who have established the purposes and objectives of the agency.

Where is social work carried on?

From our earliest colonial days governmental and private citizen agencies have taken the responsibility in various ways for people in need. "Overseers of the poor," in 1691, were public officials embodying the recognition of community responsibility for both "able-bodied and disabled" individuals who were economically indigent (paupers). Associations reflecting church or national origin, such as the Scots Charitable Society of Boston (established in 1657), were formed for mutual benefit or charitable aid purposes. As individual needs became group needs, a variety of voluntary associations developed in the fields of health, welfare, and education. As the groups became larger and the responsibility could not be met by voluntary associations, governmental agencies and programs were developed. In the early years most economic and welfare functions, including health care and education, were centered in the family. The first school (The Boston Latin School) in 1644 was a voluntary effort. The indigent sick stimulated the development of our general hospitals (1756) as we know them today. The facilities which developed publicly, like the almshouses in the 1820's, brought with them additional problems that were ferreted out by public interest. The voluntary efforts of agencies like New York's Association for Improving the Condition of the Poor (1848) addressed themselves to the problem of differentiating between those whose condition could be alleviated by helping them to a self-sustaining role and those whose condition was chronically dependent. In 1860, the Children's Aid Society of New York (established in 1853) addressed itself to the problem of placing dependent children with citizens; in a sense it was the forerunner of child welfare programs. Legislative committees made surveys and investigations of practices in the almshouses and stirred the public conscience. In the second half of the nineteenth century, State Boards of Charities and Corrections became part of the governmental structure of many states. Many localities saw the rise of charity organization societies sponsored by citizens' voluntary contributions. (Today, these are still prominent in the voluntary social work field and are known as Community or Family Service Societies.) These public and private agencies all approached their problems from a variety of human interests. All, however, attempted to understand the

indigent and to design programs which would alleviate social distress and human misery. Recurring problems brought new attempts to study and analyze; new problems brought on by political, economic, social, or international events have produced a fascinating and complex history in the design and formation of programs to meet these problems. An annual forum meets in a different city each year to compare experiences and share knowledge. In 1873, the National Conference on Social Welfare was founded as the National Conference of Charities and Corrections, and in 1963 it will meet in Cleveland, Ohio, for the ninetieth time.

This brief suggestion of social work history gives indication of the variety of fields where social work is practiced. Underlying the relationship between social work and mental health and mental illness is the principle that wherever and however one can help individuals to achieve satisfaction in socially acceptable ways, there is less danger to the emotional balance of a personality. To this extent social work has an impact on mental health, whether it is practiced in agency settings specifically established for the care and treatment of the mentally ill, such as a psychiatric hospital or clinic, or whether it is practiced in other agency settings, such as child welfare, corrections, school social work, family welfare, medical and public health, public assistance, community planning, or group service agencies.

How are social work and mental health related?

Since psychiatry has increased basic understanding of human behavior and its aberrations, mental health and mental illness have become less easily defined areas of demarcation. The long interest of social work in human capacities and limitations, the willingness of social workers to offer some help to individuals, regardless of their problems, have prepared them for this advancing knowledge. Just as psychiatry has broken down superstition from the days of witchcraft in this country, it has moved out of institutional walls to the concept of community care, and, as this broad educational effort continues and is accepted by the public attitude, psychiatry and social work move deeper into the uncharted areas of mental health promotion, the prevention of mental illness by early detection and treatment of cases, by the limitation of disability, and the many rehabilitative efforts now appearing on the scene. The possibility of preventing what has recently been called "social crippling" as a result of unnecessarily prolonged

hospitalization for mental illness has long been a concern to social agencies.

Social workers started to become concerned with the care and treatment of the mentally ill very early. The almshouses of the 1830's, into which the indigent and "worthy" poor were put, included many individuals who could not care for themselves because of a variety of mental conditions. Twenty years of social work lobbying for legislation brought the New York State Care Act of 1890 into being and gave impetus to the development of state hospitals for the mentally ill. State Charities Aid Association of New York, a voluntary agency, had for years been concerned about mental patients and their families. When breadwinners went into state hospitals as patients, the care of their families became a community concern. When the patients returned to their families, the problem of helping them pick up their responsibilities required additional help. To demonstrate this, in 1906 State Charities Aid Association of New York subsidized an "after-care agent," a social worker, to work with discharged patients of Manhattan State Hospital. This was the forerunner of psychiatric social work departments in state mental health programs in the country. Social workers are found on the staffs of most psychiatric clinical services, whether they are outpatient departments of general hospitals, school or community clinics, or wherever modern psychiatry brings its skills to bear. The social worker is considered an integral member of the "clinical team" and as such is a professional colleague of the psychiatrist and clinical psychologist. In a survey of national outpatient clinic statistics (1954-1955), the United States Public Health Service reported that 38 per cent of all professional staff time was provided by social workers.

In addition to the social worker who functions as a clinician in the psychiatric setting, many carry administrative planning and policy-making functions. They are also involved in community mental health educational and other efforts designed to impart information and to influence the community's attitude toward affirmative mental health work. These additional activities exemplify the expanding concept and understanding of mental health.

How does social work help?

Social workers, through the many programs in which they practice their profession, try to help individuals use their own personal and other resources to solve human problems. Social workers know that if a person becomes bogged down with a serious problem, his mental

health will be affected accordingly. Depending upon the individual, the emotional reaction can be anything from a mild transient reaction to a major mental illness requiring definitive psychiatric treatment. Therefore, social workers have moved into such fields as child adoption, family counseling, juvenile delinquency, corrections, group work, medical social work, community organization, and public welfare. In June 1958, the number of persons served by all public welfare agencies was 6,300,000 and the cost that month for assistance, service, and care was \$290 million. The public agencies serving over 3,000 of the nation's counties constitute the largest child caring and child serving group in the country.

The philosophy is that if we can help an individual to a more satisfying life, or to live more comfortably with himself and his problems, then there will be less likelihood of an emotional breakdown. The trained social worker is highly skilled in interviewing techniques. He has been taught a good deal about the nature and varieties of human behavior. He has been schooled to identify and to know how to use community resources to bring their facilities to bear on his clients' problems. He is sophisticated in the knowledge of community agencies and their services. As a professional he is clear about his serving role and is protective of his clients' integrity. He constantly examines his performance and seeks to improve it.

Although the individual has been stressed in this content, social work has developed methods whereby it not only works with individuals (casework), it also works with groups (group work) and with communities (community organization). These methods are highly developed, have a substantial body of literature, and are taught in graduate schools of social work.

Where does the professional social worker get his training?

Professional training for social work began with the establishment of the New York School of Philanthropy in 1898 (now Columbia University New York School of Social Work). There are currently fifty-six accredited schools of social work in the United States and seven in Canadian universities. A two-year course of concurrent classroom and supervised fieldwork leads to a master's degree. In June 1961, 2,310 individuals received master's degrees in social work. Sixteen United States universities offer doctoral degrees in social work. New schools are continually being developed and their curricula are evaluated and accredited by the Council on Social Work Education.

How many social workers are there in the United States?

Studies have been made by the United States Bureau of Labor Statistics and the National Social Welfare Assembly. They identify 105,351 social workers in 1960. Of these, 63 per cent were employed by federal, state, or local government and 37 per cent worked in voluntary nonprofit agencies. The number of those considered to have basic professional training was 21 per cent. Only 9 per cent of the total group did not have a college education.

How many social workers are needed?

Social workers have been, and in the near future will continue to be, in chronic short supply. To estimate the exact need is extremely difficult, since new programs calling for their employment are constantly being conceived. In June 1962, it was estimated that there were approximately 12,000 to 15,000 unfilled positions for which budgeted funds were available. To take an illustration of the projected determination of need for future social workers:

The staff of the United States Bureau of Public Assistance (now the Bureau of Family Services) and the Children's Bureau under the Social Security Administration, Department of Health, Education, and Welfare have projected a 1970 goal of 44,500 additional fully trained social workers. This is the considered estimate of one large agency with many functions—and only represents a percentage of the agency's present total staff. It is clear that the fields of social work, in the foreseeable future, will continue to be manned by heterogeneous staffs that will vary from untrained to partially trained and fully trained personnel. Many programs will use the services of volunteers who will be selectively trained for particular tasks.

How can anyone identify professional social workers?

The simplest way is to ask for credentials. When the public seeks any service of a professional, lawyer, doctor, or accountant, there are simple determinants like a license or a certificate. This is more difficult in social work since only a few states have so far passed legislation to restrict the title "registered social worker" to the professionally trained practitioner. A number of state legislatures are considering bills to help the public identify such qualifications for their own protection. However, since most social workers practice under agency auspices and will on request produce evidence of their training and other credentials, it is best to be quite direct and ask for it. The

qualified worker will appreciate such candor. On December 1, 1961, the Academy of Certified Social Workers, a national standard-setting organization, gave the general public a clearer method of identification. Qualified members now have the certificate, "A Certified Social Worker."

There will be qualified individuals without these credentials but they will need further evaluation. For example, a fully trained social worker will require two years of accredited supervision by a qualified supervisor before certification.

Is there a professional membership organization?

The National Association of Social Workers is the single professional membership organization. Comprising about 35,000 members, it is the outgrowth of a merger of five predecessor groups. Professional social workers first developed an organization of medical social workers shortly after 1915. They were followed by psychiatric social workers and several others so that a segmented group of organizations with a variety of membership requirements spoke for the social work field of their interest. In 1955, the American Association of Group Workers, the American Association of Medical Social Workers, the American Association of Psychiatric Social Workers, the American Association of Social Workers, the Association for the Study of Community Organization, the National Association of School Social Workers, and the Social Work Research Group memberships joined together to form the National Association of Social Workers. The basic membership requirement is graduation from a school of social work accredited by the Council on Social Work Education. The National Association of Social Workers has a broad program of publications and is the single responsible spokesman for the professional membership. It has a code of ethics and is eager to improve all aspects of the public image of social work.

What is social casework?

It has already been noted that all trained social workers have been given basic information regarding disease, both physical and mental. Wherever social workers practice and professionally involve themselves with individuals, they must have a grounding in personality development and its aberrations. A great deal of knowledge and skill must be available to the social worker who makes decisions regarding the proc-

ess involved in the adoption of a child, counseling with families, and making a variety of community services available to handle cases of social pathology. In all situations the social worker should be able to distinguish between that portion of the problem which is the result of real factors and those aspects of the situation which are created by the emotional needs or shortcomings of the person who comes to him for help. The capacity for this type of differentiation is part of the skill and technique of all social workers who are trained in the casework process. As they work with an individual and his problem, social workers develop an understanding of that individual's situation, his accustomed manner of coping with problems, his strengths, and his weaknesses. The objective of the casework relationship is to help the individual find new ways of behavior, thus enabling him to accept the solutions that are reasonable and possible within existing reality limitations.

At the starting point, the social worker accepts the individual as he is and where he is—a person with a problem who has come to him for help. The relationship grows as they begin to understand one another and as they correct first impressions and misconceptions. The client may have a variety of expectancies gathered from previous related and unrelated experiences, or he may be accustomed to dumping his problem into the lap of someone who will take it over and tell him all the answers. It will soon become apparent that the social worker is a person who is interested in the client's life situation and is willing to work with him and his difficulties, but will assume only such responsibility as is realistic within his technical skills and the agency resources or community facilities that may be available. Thus, the casework process can be a constructive experience for the individual who is so closely involved with himself that he has become completely frustrated because he does not know where to turn next. Frequently, even when solutions to problems do not result from the casework relationship, the client may achieve a different perspective—one that will make his chronic situation more tolerable.

The social caseworker maintains a constant attitude of inquiry and acceptance of the client. He has to be aware of his own attitudes, interests, concerns, and standards. He has to be careful not to confuse these with the attitude of the client. He must exercise restraint in making decisions, and rather suggest alternatives and discuss choices so that the client may have a maximum of latitude for decision. This supplies the motive power for the client to act and achieve in his own behalf within

his own capabilities. Out of such a process an individual may replace his dissatisfaction with an experience of satisfaction.

An important factor in social work practice is the special nature of supervision and supervisory practice, not matched consistently in any other profession. Both in his training and in his practice the efforts of the social worker continue to be under close scrutiny. This is a built-in process that helps the practitioner to develop his skill and examine his practice, as well as to have colleague consultation at all times. It is also an insurance to the client that when his problem is one that is not amenable to social work help or is beyond the competence of the social worker, appropriate safeguards and referrals to other resources will be made.

What are other social work methods?

Like other professionals social workers specialize. Some of the fields of social work have already been suggested. Social casework as a method has been briefly discussed. Other methods, e.g., group work and community organization, have also been mentioned. Offering service to groups has become more developed in recent years. This ranges from general activity groups in community centers, or youth groups directed at efforts to ameliorate influences thought to bear on the problems described under the heading of "juvenile delinquency," to very circumscribed groups of patients in mental hospitals where group techniques have been found effective. Community organization in social work has taken on a rather special character which has grown out of the general social work philosophy and training. Although the term is used by other professional disciplines, e.g., public health, the process employed by social workers has a distinctive character and a mark of participation that is its own. It is seen in local, state, and federal operations as a highly sophisticated technique requiring considerable skill. Although research and administration are not methods unique to social work, they take on a particular coloration and emphasis in this context.

What is psychiatric social work?

Unfortunately, this has become a value term in some quarters, both professional and lay. All professional social work training is generic and as such social workers are academically trained in similar content. However, all practice of social work is performed in specific settings. Therefore, it is important to have a knowledge of this specific adaptation of general social work training.

Adding the adjective "psychiatric" to social work has been grossly mis-

understood. For years the American Association of Psychiatric Social Workers clearly defined a position that has remained unchanged. The A.A.P.S.W. had always insisted upon training and practice standards. However, it defined the field of psychiatric social work as "social work practiced in direct and responsible working relations with psychiatry." The effort was succinctly to maintain the identity of social workers who undertook to practice their profession conjunctively with the medical specialty of psychiatry. The efforts of this segment of social workers resulted in the inclusion of what was known as the psychiatric sequence in the curriculum of schools of social work as early as 1916. This specialized training used to be reserved for social workers who elected it in preparation for practicing in psychiatric agencies. In the 1940's, however, all accredited social work training began to require such courses.

The special difference of the psychiatric social worker is that he practices in a psychiatric setting. As such he is clearly identified with the medical service he represents and carries a delegated medical responsibility, which social workers in other settings do not. He becomes more attuned to deviations from the normal behavior since medical services are sought when the individual sees his problem as an illness rather than as a problem in social context such as marital discord or a problem of adjusting to a school situation. Essentially the psychiatric social worker, therefore, complements his special skills and competence with those of psychiatrists by assisting them to give their patients a comprehensive service. Some social agencies may use psychiatrists in a consulting role but do not consider themselves as agencies offering medical services to the public.

Practicing in a psychiatric setting does not require different or more training than that expected of social workers in other settings. Nor is the element of skill to be valued higher in this sphere than that to be found by the social worker whose setting is child adoption or a family society.

Where are psychiatric social workers found?

Psychiatric social workers have become integrated with any psychiatric service that attempts a complete service. In mental hospitals, general hospitals, and other inpatient or outpatient services, social workers will be on the staff working with patients either individually or in groups. In community mental health clinics, for either children or adults, the "intake" worker will usually be a psychiatric social worker. He will be the individual with whom you will first discuss your

interest in the service. He will tell you the kinds of services the agency has to offer in connection with the kind you are seeking. He will answer your questions regarding the diagnostic and treatment processes, cost, frequency of appointments, and other practical considerations. You will be able to consider with him the appropriateness of the facilities that will meet your needs. In all probability the social worker will provide the thread of continuity for the patient during a variety of procedures and therapies. At various points in the course of treatment the social worker may play a minor or major role in keeping with the medical plan.

In addition to specific clinical roles in connection with patients, social workers participate in mental health programs in a variety of non-clinical ways. They may have important administrative posts in community services such as community mental health boards. They may act as consultants to mental health programs or participate in mental health education. The social work community organization training and know-how are especially valuable in assisting in the creation of new mental health agencies.

Is social work practiced privately?

Social work is found mostly in group practice, such as governmental subgroups or voluntary agencies. However, there has been some private practice in existence for thirty or more years. It usually has been on an individual arrangement basis between a psychiatrist practicing privately and an individual social worker. However, more and more in recent years social workers have individually offered their services to the public. Acting on the recommendations of the National Commission on Social Work Practice, the Board of Directors of the N.A.S.W. stated desirable minimum qualifications for social workers engaged in private practice in May 1961. In brief these are: (1) graduation from an accredited school of social work; (2) membership in the N.A.S.W.; (3) membership in the Academy of Certified Social Workers; and (4) five years of experience in agencies under qualified supervision.

The Board of Directors of the N.A.S.W. defined private practice: "A private practitioner is a social worker who, wholly or in part, practices his profession outside the aegis of a governmental or duly incorporated voluntary agency, who has responsibility for his own practice and sets up his own conditions of exchange with his clients, and identifies himself as a social work practitioner in offering his services."

SPEECH DISORDERS

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What is a speech disorder?

A speech disorder is a deficiency, distortion, or disturbance of speech that makes a significant difference to the speaker, or to the listener, or to both in their attempt to communicate with each other.

What are the various types of speech disorders?

There are disorders of language, voice, speech-sound articulation, and speaking rate and fluency, as well as stuttering. The main disorders of voice are aphonia, or lack of voice; hoarseness, breathiness, harshness, and excessive nasality; and loudness or pitch, or both, that are too high, too low, or monotonous. Disorders of articulation may involve omission of sounds, as in "pay" for "play," or substitution of one sound for another, as in "wan" for "ran," or distortion of sounds as in a mused or whistled "s." Rate of speech may be too fast, or too slow, or uneven. Speech may vary in fluency. All speakers are hesitant, repetitive, and in other ways disfluent, some more than others, and any speaker is more disfluent when frightened, excited, fatigued, or uncertain. Disfluency may also be associated with certain kinds of brain damage or with neurosis.

The disfluency involved in the problem of stuttering differs from other disfluency in its association with distinctive feelings of concern, fear, or embarrassment, and with distinctive patterns and degrees of tension. The tension and strain of the stutterer arises chiefly from his effort to hold back, so as not to stutter again, at those times when he feels he will stutter if he goes ahead. Stuttering varies greatly; it seldom occurs when the speaker is alone, or in singing, reading in chorus, etc.

Aphasia is a general name given to deficiencies and disturbances of language due to brain damage, particularly cerebral vascular accidents (strokes), tumors, and traumatic injuries. Aphasia may affect reading, writing, speaking, and the understanding of speech. It commonly involves difficulty in recalling names or in word finding.

How many individuals in this country are afflicted with speech disorders? Is this rate changing?

Probably three to five out of every hundred persons have impaired speech. Comparatively larger proportions of the very young and very old have speech that does not meet the general standards of normality. Over 5 per cent of children in the early grades need speech correction; the percentage drops to 2 or 3 per cent in high school. Among patients in geriatric hospitals, over 25 per cent may have severe speech and language disorders. Disorders of speech associated with neurological impairment, cancer of the larynx, and severe hearing loss are probably increasing simply because the proportion of our population in the older age brackets is increasing. Speech correction is reducing the rate of incidence of speech disorders among schoolchildren, but the total number of schoolchildren is increasing.

Are there more speech disorders among particular nationalities? Religions? Races? Social or economic groups? Sexes?

We do not know definitely whether national, religious, or racial groups differ in the incidence of speech disorders. There may be more articulation disorders and delayed development of speech in the lower economic levels, to the degree that economic level is associated with the level of mental ability and with the amount of speech stimulation, since there are somewhat more disorders of these types among the mentally subnormal and the underprivileged. There may be more stuttering in families that are striving to rise in the socioeconomic scale, and that tend to be, therefore, more perfectionistic and demanding with their children. Generally speaking, more males than females have speech disorders. For every girl there are from two to four boys who come to be classified as stutterers. Recent studies indicate that young boys and girls speak about equally fluently, and so the sex difference in incidence of stuttering may reflect a difference in the way boys and girls are reared and in the way their early speech is judged by their parents.

Are the causes of speech disorders physical? Psychological? Hereditary?

Different disorders of speech have different causes. Some articulation disorders are due to faulty learning, while others are related to such conditions as cleft palate or cerebral palsy. As has been indicated, aphasia is associated with brain damage or disease. Surgical removal of the larynx, or voice box, because of cancer, results in loss of voice; patients who have had this kind of surgery can be taught to speak by

swallowing air and vocalizing it as they expel it, or to use mechanical or electrical artificial larynges or "voice makers." It has not been thoroughly established that any speech disorder, as such, is hereditary. What a person inherits is a body with its distinctive structural features such as eye color and skeletal structure. Because one inherits a voice box, throat, and mouth of particular size and shape, tone of voice may be said to be inherited because it is dependent to some degree on these physical features. The problem of stuttering often runs in families, but so do political leanings, religious preferences, and the like. Parental attitudes and practices with regard to the speech training of children probably do run in families, and so far as these are responsible for stuttering, the tendency of the problem to run in families may be accounted for on this basis.

When do most speech disorders begin?

Some disorders, such as those associated with cerebral palsy, are present from the beginning of speech. Many articulation problems begin with the learning of faulty ways of forming certain speech sounds during the first one to three years. Aphasia begins with the brain damage or disease to which it is due, at whatever age this occurs. The problem called stuttering usually begins between the ages of two and a half and four years.

Is the individual always aware of his speech disorder?

Yes, with two main exceptions. First, one cannot always be sure of the mentally retarded child's awareness of his speech. Second, when a parent first decides that a child is stuttering, the child himself may not feel that anything is wrong. In other words, at first the problem is that of the listener rather than that of the speaker. What the child first becomes aware of is not that he is speaking differently, but that his speech is not well received by his listeners.

Might a speech disorder cause other disturbances? What can be done to prevent this?

It is mainly through speech that human beings relate to each other. Any significant impairment of a person's ability to speak or to understand and respond to speech necessarily affects his relationships with others. It also affects, therefore, the feelings he has about himself.

The aphasic patient, for example, may experience feelings of insecurity, loneliness, confusion, and depression upon finding, after a long business career, that he cannot remember names, understand directions, or make himself understood by his friends and loved ones. Once a child has been regarded by his parents as a stutterer and comes to speak to them more hesitantly and uncertainly because they seem not to approve of the way he speaks, he may develop considerable evidence of uneasiness and tension in speaking. Speech characterized by such conflict and tension is what we usually mean clinically by stuttering, and such speech may occasion difficulty in social and personal adjustment for the speaker. Conditions such as cleft palate or cerebral palsy, which are sometimes associated with a speech disorder, may impair the speaker's self-regard and add to his difficulty in social relationships. What can be done mainly to prevent a speech disorder from resulting in adjustment difficulties is to help the speaker and his family cultivate the perspective and the attitudes that will enable them to minimize embarrassment and discouragement and to make the most of the individual's capacity for speech. Effective clinical speech services and related counseling are the major approach to this problem.

Might a speech disorder be a sign or symptom of a more serious disturbance?

This question has been answered in part by the references above to aphasia, speech disorders associated with cleft palate and cerebral palsy, mental retardation, etc. It is to be particularly noted that extensive research has failed to substantiate the more or less popular notion that stuttering is a symptom of emotional disturbance; stuttering, however, may be the cause of considerable emotional distress.

Can a serious emotional experience later in life cause stuttering? On what might this depend?

A fundamental distinction is to be made between disfluent speech, as such, and the problem called stuttering. Unusual or excessive disfluency may be due to many factors. Some of these may occur later in life. Certain illnesses, brain injuries, excessive fatigue, or the effects of alcohol or certain drugs, or excitement, grief, and other emotional experiences, that can occur almost any time in life, may be accompanied by unusually hesitant or disturbed speech. Disfluent speech, as such, however, is not all there is to stuttering, which is characterized by

distinctive tension, fear of stuttering, and embarrassment over it. The problem called stuttering usually begins around the age of three years.

What is stuttering? What percentage of the words spoken by a stutterer are stuttered?

As has been explained above, stuttering is a problem that involves a speaker, one or more listeners, and the interaction between them. This problem characteristically arises first in the listener (the parent) who comes to feel that the speaker (the child) is not as fluent as he should be. When the parent first feels that the child is not speaking fluently enough, the child may be speaking very fluently, very disfluently, or somewhere in between. In the usual case he is repeating sounds or syllables or whole words or phrases or interjecting "uh, uh, uh" or other sounds indicating hesitation or uncertainty in choice of words. These forms of disfluency are to be observed in the speech of all children. When a child is first regarded by his parents as a stutterer, he may be speaking either less or more fluently than the average child of his age. He may be speaking with much more disfluency than usual, but under conditions of excitement, confusion, great fright, injury or disease, so that his unusual disfluency is "normal under the circumstances." He may or may not react to his disfluency with some degree of tension, struggle, or distress. What is crucial is the relationship that develops between the child, as the speaker, and his parent, as the listener. If the listener is concerned and reacts so as to influence the child to feel concerned about the way he is speaking, then the child's speech will be affected, in turn, by the concern that he feels. If the child himself has no reason to become concerned about his speech, it is to be expected that his speech will return to its usual degree of fluency when the conditions which have disturbed it have passed. If he does become concerned and tries to avoid hesitating, and if he experiences conflict over whether or not to speak or to hold back, he will develop the apprehensive and tense avoidance reactions that are recognized clinically as stuttering. As an average adult stutterer he will stutter about ten per cent of his words. Most stutterings last less than one second, but an occasional one lasts for a minute or longer.

What is the difference between stuttering and stammering?

Historically, "stammering" was sometimes used to refer to tense speech blockages, while "stuttering" was used to refer to repetitive dis-

fluencies. Today these two words generally mean the same thing. In England and in some other parts of the world the term "stammering" is preferred; in the United States the term "stuttering" is preferred.

Are there certain physical activities particularly characteristic of the behavior called stuttering?

Clinically significant stuttering involves the more or less tense prolonging of sounds and repeating of the first parts of words or whole words or, in some instances, phrases. It may also involve holding the breath, pressing the lips together tightly, clamping the jaws together, or associated movements such as tightly blinking the eyes, turning the head, and movements of the arms, feet, or other parts of the body. In general, these movements are essentially struggle reactions expressive of the speaker's conflict between his urge to speak and his desire to avoid the stuttering which he is afraid he will experience if he begins or continues speaking.

Are there periods when stuttering is reduced? When? Why is this so?

With few, if any, exceptions, persons who stutter can sing, can read or speak in chorus with others, even with other stutterers, talk in time to rhythms as in saying one word to each step while walking, and they can speak easily and comfortably when alone. In a very real sense it takes two persons to stutter. Moreover, stutterers speak better to certain listeners than to others. These variations in stuttering are probably due primarily to past learning and the immediate attitudes and reactions of the listeners and of the speaker. Most stutterers talk more fluently to listeners who are sympathetic and friendly and who encourage the stutterer to go ahead and talk and not worry about whether or not he is fluent. Likewise, stutterers talk better when they enjoy speaking and don't care too much whether they stutter or not, and when they are most thoroughly self-accepting.

Is stuttering a sign of low intelligence?

No, it is not.

Do stutterers have small vocabularies? Do they have larger vocabularies than they use?

There is probably no basic or important difference in vocabulary between persons who stutter and those who do not. Some stutterers do develop a habit of substituting words which they think they can say

for those on which they are afraid they will stutter. Because of this habit they probably cultivate somewhat larger vocabularies than they would otherwise.

When is it best to start treatment for stuttering? How can stuttering be treated? Why does it seem that a "cured" stutterer sometimes reverts to his stuttering in time of emotional stress?

The best time to do anything about the problem called stuttering is as soon as possible after it has arisen. When the child is very young and the problem exists primarily in the feelings and behavior of the parents, treatment consists mainly of counseling the parents, as the child's most important listeners. In general, the parents are given information about the conditions under which children speak more and less fluently, are helped to understand how they can make speaking more rewarding and fun for the child, and how to eliminate conditions under their control that are disturbing to the child's speech. After the child has become his own most disturbed and disturbing listener, therapy may be more difficult and may take longer. In most modern speech clinics the older child or adult who stutters is helped to understand what he is doing that interferes with his otherwise fluent speech, and to recognize the conditions under which he does these things. He is helped to build confidence in his ability to speak normally. He may be encouraged to block and interfere with his speaking "on purpose," in order to sharpen his insight that stuttering is indeed made up of things that he himself does, and that by doing them he keeps himself from speaking as well as he can. He may be instructed to do his stuttering in different ways, to do it more strenuously and more easily, in more complicated or more simple ways. He is encouraged, in due time, to try talking more and more without doing the things that are called stuttering. The clinician tries to get him to do more talking, and to practice talking with the new attitudes and confidence which his new knowledge and understanding—and improved speaking—give him. So far as the stutterer achieves these kinds of change, he speaks more easily and smoothly. It is often possible to achieve important changes in the speech of older children or adults within a few weeks, but substantially complete improvement is more likely to take two to three years or longer. Most stutterers never completely lose the memory of past distress in speaking, and they may revert to some degree of anxiety and related reactions under the particular conditions that have been most strongly associated for them with their greatest distress in speaking.

Stutterers can be hopeful of achieving improved speech in most modern speech clinics.

Can stuttering stop by itself?

Stuttering is done by the speaker, as has been explained, and he can stop doing the things that make up the stuttering, but "it" can hardly stop "by itself." Some speakers do stop stuttering without knowing why or how they stop.

What methods of treatment for speech disorders are available?

Treatment varies, of course, with type of disorder, but in all cases the speaker needs the information that will enable him to understand his problem and to see his specific possibilities for improvement. He needs to practice the desired speech changes and to be encouraged and counseled as he tries to change his speech habits. The speaker who misarticulates sounds benefits from hearing repeatedly the correctly formed sounds and from trying to match them. He must learn to make each sound as it occurs in words and sentences and in connected speech. Organic conditions associated with a speech disorder are to be given appropriate attention. In cases of cleft palate, for example, the best possible surgery is desirable or, if surgery is not feasible or sufficient, prosthetic appliances can be used to compensate for the cleft, and dental repair may be helpful. Speech therapy is desirable in most cases of cleft palate. Treatment of voice disorders that are associated with organic pathology is carried out by the speech pathologist in cooperation with the otolaryngologist. The speaker may benefit from changing his accustomed level of pitch or loudness in speaking. If his voice problem is associated with some emotional disturbance, he requires counseling accordingly. The treatment of aphasia is dependent upon a thorough analysis of the specific deficiencies and abilities of the speaker. He needs systematic and intensive training in attempting to use and understand the affected words and language forms or functions. He and those associated with him in the family or in the clinic need counseling and instruction concerning the problem and the essentials of effective language retraining.

What success do these methods achieve?

Present-day remedial speech methods are relatively successful. Their success depends upon the nature of the specific speech disorder being treated, the appropriateness of the methods used, the skill of the

speech clinician, the motivation and work habits of the patient, and the cooperation of family, physician, nurses, teachers, and others importantly related to the patient.

What agencies, institutions, or school programs are there in the community that are specifically concerned with speech disorders, their prevention, and treatment? What are the qualifications of professionals in this field? What is the cost of clinical speech services?

The American Speech and Hearing Association, 1001 Connecticut Avenue, N.W., Washington 6, D.C., is the national organization of professional clinical and laboratory workers and teachers in the field of speech pathology and audiology in the United States. The association provides clinical certification for its qualified members. The requirements for certification include training to a level generally equivalent to that of the master's degree, or beyond, plus substantial supervised clinical practice and paid experience. A steadily increasing proportion of workers in this field hold doctoral degrees. There are approximately 8,000 speech pathologists and audiologists in the United States at the present time; it is estimated that there is a need for at least 25,000, and this number will increase as our population grows. The graduate programs of professional training provided by the universities are being gradually upgraded as research and clinical experience yield increased knowledge and professional skill and improved methods. More and more of the nation's public schools provide speech correction services for their pupils, and many colleges and most universities today have speech clinics in which students are served. Clinical speech services are available in speech clinics in colleges and universities, in hospitals and community clinics, in rehabilitation centers, and in schools for handicapped children. There are also speech pathologists in private practice. The cost of these services depends on the nature of the problem in each case. In schools and colleges, clinical speech services, when available, are provided for students either free or for a nominal charge. For other persons the usual cost of clinical speech services, in clinics or in private practice, is generally moderate and reasonable.

Information concerning clinical speech services may be obtained from the American Speech and Hearing Association.

Can speech disorders be prevented? How?

Speech disorders associated with organic conditions, such as cleft palate, cerebral palsy, or brain damage or disease, can be prevented to

the degree that these conditions are prevented, or so far as such conditions can be so treated medically or surgically as to prevent the development of speech disorders. Articulation disorders not associated with organic conditions can probably be prevented to a worthwhile degree by proper speech stimulation and parental and school practices and policies favorable to the learning of correct patterns of speech-sound articulation by the child. Stuttering has been called "an avoidable accident" and can probably be substantially prevented through elimination of such parental evaluations and reactions as disapproval of, and persistent concern over, the disfluencies of childhood speech, and perfectionism generally about speech, table manners, cleanliness, etc. Stuttering is least likely to develop when the parents enjoy listening to the child talk, accept the way he talks, are generally relaxed, are sensible and reasonably consistent in discipline, and make speaking fun and worthwhile for the child.

From current research, what might be predicted about the prevention and treatment of speech disorders in the future?

We can be hopeful that the incidence of speech disorders can be reduced in the future. This is particularly true of stuttering and the disorders of articulation that are due to faulty learning. There is also the possibility, through improvement in surgical procedures, of a reduction in the proportion of children with cleft palate who need to be burdened with impaired speech. With the rise in number of older persons will go an increase in incidence of speech disorders, but this increase should be counterbalanced by improved means of prevention and methods of treatment.

STERILITY

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What is sterility?

Sterility (infertility) is the inability to have children. The American Society for the Study of Sterility has stated: "A marriage is to be considered barren or infertile when a pregnancy has not occurred after a year of coitus without contraception." Note, however, that both marital partners can be fecund, i.e., able to procreate, but still have an infertile marriage.

To whom does the term apply?

The term applies to a man who cannot impregnate a woman, to a woman who cannot become pregnant, or to a couple who cannot have a child of their own.

What are the physical causes of sterility?

In a woman these include: (1) absence, defect, or disease of the sex glands (ovaries); (2) failure of the ovaries to develop normal germ cells (ova); (3) blockage of the tubes so that the ova fail to reach the womb (uterus); (4) absence, defect, or disease of the uterus, precluding nourishment and development of a fertilized ovum; (5) blockage of the entrance to the uterus (cervix) preventing male germ cells (sperm) from reaching the ovum; or (6) absence, defect, or disease of the vagina sufficient to destroy the sperm, or block their entrance into the uterus.

Physical causes of sterility in men include: (1) absence, defect, or disease of the sex glands (testes); (2) absence or blockage (due to defect or disease) of the minute tubes that carry germ cells (spermatozoa) from the testes to the penis; or (3) defect or disease of the penis sufficient to block the tube (urethra) through which sperm must pass into the woman's vagina. In both men and women, diseases or deficiencies involving the whole organism may cause or contribute to sterility. Severe vitamin deficiencies, for example, or endocrine (hormonal) disorders, or such debilitating conditions as malnutrition, tuberculosis, etc., can be responsible.

The most common physical cause for sterility, of course, is failure of sexual partners to have intercourse at a time when impregnation can occur. The reasons may be psychological, but physical action is involved. The most fertile period is around fourteen days before the onset of the woman's menstrual period regardless of the length of her cycle. Another factor, often overlooked, is douching immediately after intercourse. This measure of supposed delicacy and "cleanliness" can be an effective contraceptive. Some physical causes of sterility are therefore impossible to change, but many, perhaps the majority, can be successfully treated. (See *Menstruation and the Sexual Cycle*)

What are the psychological causes of sterility?

These are many, varied, and debatable. Authorities assume significant psychological causes, but many are unproved. (See *Frigidity; Impotence*)

Consider, for example, why one or both partners consciously or unconsciously avoid sexual intercourse. Reasons range from an entirely conscious aversion to the partner, to deeply unconscious fear or guilt about sex, pregnancy, or parenthood. There are women whose sexual desire is greatest close to or during menstruation, when impregnation is least likely to occur. Such a paradoxical situation might indicate a wish for sexual gratification without conception. Spasm of the tubes precluding pregnancy can occur in women who nevertheless enjoy frequent sexual intercourse. Comparable emotional conflicts in men can cause avoidance or bad timing of intercourse.

Can sterility be a symptom of a physical disorder?

Yes. It is useful, however, to distinguish sterility from lack of fecundity. Relatively few physical conditions make it absolutely impossible for a man or woman to produce germ cells (ova or spermatozoa) or to create the necessary conditions for fertilization. Many physical illnesses or other states (fatigue, for example) conspire to reduce sexual desire or the frequency of sexual intercourse and thereby decrease the chances for conception.

Can sterility be a symptom of a psychological disorder?

Again, yes. In one study nearly 30 per cent of the cases coming to a sterility clinic had psychological problems causing or contributing to sterility. Someone has remarked that feelings of guilt about sex are about as common in our civilization as sexual activity itself. It is not

astonishing, therefore, that sterility is a by-product if not a direct consequence of neurotic conflicts. The most obvious expression of such conflicts is seen in the total avoidance of sexual intercourse. (See *Impotence; Frigidity*)

What is the rate of sterility in this country? Does it differ from that of other countries?

Sterility rates are very difficult to establish. One has to discount, for example, the "sterility" due to planned abstinence and other forms of birth control. It has been estimated, however, that about 10 per cent of marriages are sterile in the sense of there being no children or not as many children as desired during the years when reproduction was possible. This 10 per cent does not represent absolute infertility; perhaps a third of this number might have achieved fertility with the help of a physician or clinic.

Comparison with other countries is likely to be meaningless. One can match birthrates, infant mortality, size of families, and the like, but it is impossible to know much about such factors as accuracy of reporting or the extent of birth control or abortion. An African study, for example, revealed extreme reluctance to report sterility because of the stigma involved. Much of what was revealed was due to widespread venereal disease—most of it preventable and much of it treatable.

Is the incidence of sterility greater among one of the sexes? Certain occupational groups? Certain economic groups? Religious groups? National groups? Racial groups?

It used to be assumed that the wife is responsible for a barren marriage, and this attitude still persists. Some authorities state, however, that the husband is responsible in 30 to 50 per cent of such marriages; others assert that the ratio is about fifty-fifty. Evaluation of a sterile marriage must include both husband and wife.

In considering sterility according to various groups, it is again useful to distinguish fecundity from fertility, i.e., the potentiality for having children from the actuality of having them. It is estimated that fecundity is about the same the world over. Healthy couples anywhere would have an average of ten or eleven children if they were sexually active without contraception throughout the childbearing period of life. This potential does not vary significantly with race, class, or creed.

Factors that influence fertility, i.e., the actual number of offspring, are those that determine the frequency of sexual intercourse, the length of exposure to childbearing (early or late marriage, for example), the

use of contraceptives, and the health of the marital partners. Age is the most important determinant in the frequency of sexual intercourse, according to Alfred Kinsey's report; and it is generally known that the chances of pregnancy fall off rapidly after the age of thirty. Statistically, the period of greatest fertility is under twenty, with the period between twenty and twenty-five a close second. Some authorities believe that the length of marriage before impregnation is attempted may be an even more important factor than age. In any event, the longer a married couple postpones trying to have children, the less are their chances of having them or, at least, having as many as they may desire.

Is sterility hereditary? Do low procreation rates tend to run in families?

There is no conclusive evidence that sterility is hereditary. Some authorities believe that this is so—because it is in some animals—but definitive research remains to be done. So far as is known now, a hereditary factor would cause relative infertility—probably because of low sexual drive—rather than absolute sterility.

Experts on the problem of sterility are extremely reluctant to be dogmatic about the relative importance of psychological, environmental, or even physical causes. Absence of the generative organs or complete abstinence from sexual intercourse are, of course, absolute causes. So far as physical disease is concerned, only pelvic inflammatory disease or pelvic disease complicated by fibroid tumors of the uterus are definitely known to diminish the chances for pregnancy. In the male, total inability to produce sperm or to discharge them during sexual intercourse are equally absolute. As regards a host of other factors there is often more surmise than proof.

One example of a male factor in sterility is that of working under conditions of extreme heat sufficient to inhibit the production of sperm. Comparable to this can be relative overheating of the testes from tight or excessive clothing or long hours of sitting, as in the case of bus or truck drivers. In both sexes, fatigue, nervous strain, and all that goes with emotional or physical exhaustion are presumptive factors in sterility. Obviously there may be a combination of physical, psychological, and environmental influences, but it is extremely difficult to pinpoint their relative importance. When low procreation rates appear to run in families, the chances are that the persistence of factors such as those mentioned above explains as much as a possible hereditary element.

Does the rate of sterility increase during conditions of stress?

The relationship of stress to sterility is not definitely known. Although it is assumed that emotional stress (creating so-called "nervous exhaustion") or other stresses leading to physical exhaustion contribute to sterility, it is part of our folklore that other kinds of stress have just the opposite effect. Thus, the birthrate is supposed to go up during wartime and, according to the old song, "the rich get richer and the poor get children." Actually, according to the *Statistical Abstract of the United States (1959)*, the birthrate in this country was around 24 per 1,000 population during World War I, down to about 17 per 1,000 population during the "depression years," up only slightly, about 18.5 per 1,000 population, during World War II, and in the years since 1952, averaging about 24.75 per 1,000 population. Many factors determine the birthrate.

Sexual intercourse may be inhibited by anxiety, for example, but may be equally facilitated by it. As a source of solace and comfort at times of sorrow or worry, more frequent intercourse may reduce sterility. Although statistical proof is lacking, one can conjecture that mild stress diminishes sterility, while severe stress increases the incidence. In any case, the kind of stress and the individual reactions to these various kinds are highly important considerations.

Can sterility create other problems?

Yes, but it is difficult to distinguish the problems directly caused by the fact of sterility from problems that may simply be associated with it. There is, for example, some relationship between sterility and fibroid tumors of the uterus. One German gynecologist claimed, however, that it is not a case of one causing the other, but rather that both may result from chronically disturbed psychosexuality and concomitant alterations in the blood and lymph supplies to the uterus. A recent, very thorough study of sterility, however, makes no mention of physical consequences.

Psychological effects of sterility are multiform. Some couples are easily and happily reconciled to being childless. Others react with varying degrees of regret, resignation, and sorrowful acceptance. Still others suffer moderate to severe feelings of social stigma, inferiority, or deprivation. A given individual is sometimes guilty or ashamed because of the conscious or unconscious assumption—perhaps mistaken—that the present infertility is his or her fault and is doomed to be permanent. The "fault" is often regarded as a punishment for childhood masturba-

tion, premarital sex relations, or marital infidelity. The sense of guilt or sin often obscures the medical problem. Just as often, perhaps, there are silent (or not so silent) suspicions of the marital partner and consequent added strains within the marriage. Helene Deutsch found intensified narcissism and aggression in many sterile women. Comparable reactions are, of course, to be found in men.

Social effects of sterility vary with the culture. If regarded as a stigma, it can lead to withdrawal and isolation. It remains a reason for divorce in some parts of the world. Beyond such considerations is a host of others related, for example, to the "population explosion." It would appear that Oriental populations will far outnumber the Occidental, that Catholics will move further ahead of Protestants, and that "lower" uneducated classes will increasingly exceed the "upper" educated classes—although this last is currently reversed in the United States. At the same time, however, the birthrate among nonwhite mothers during the period 1940 to 1947 in the United States has pulled steadily ahead of that for white mothers. Whatever the ultimate outcome of such trends, their social consequences are manifestly of great importance.

What is the incidence of couples having their own child or children after adopting a child? Why is this so?

All that can be said, really, is that this happens frequently. One survey indicates that the percentage of pregnancies following adoption was no greater than might have been predicted anyway (from a statistical point of view), but the validity of this study—by questionnaire—has been questioned. In any case, it is a matter of common observation that a first pregnancy often does occur after an adoption or even after making the decision to adopt. The very resolution to do something about sterility may be of greatest importance. Beyond this, such factors as the wife's quitting her job or career, the reaffirmation of the marriage, the actual experience of parenthood with an adopted baby, and the "relaxation" of any number of doubts and tensions in these ways can be, literally, of vital importance. (See *Adoption*)

What part can endocrine factors play in the cause and treatment of sterility?

Knowledge of the endocrine factors in reproduction is still far from complete, and their role in most cases of sterility is virtually unknown. Endocrine products of the thyroid, pituitary, adrenals, sex glands, and the sex cells themselves are apparently vital at various stages

in the complex processes of reproduction, but it is seldom possible to pinpoint an endocrine problem when pregnancy fails to occur. The mysterious interaction of emotional and endocrine influences is doubtless a major reason for this state of affairs.

Authorities agree that the medical investigation of sterility should be most thorough and should include both partners. Even if everything appears to be "normal," the physician should correct apparently innocuous degrees of anemia, nutritional deficiencies, or hypothyroidism. At the same time, however, physician and patient alike must accept the fact that there are only limited indications for endocrine treatment of sterility. In men, hormone therapy may be helpful in cases of mild degrees of sperm malproduction or related conditions of inadequate spermatogenesis. As far as women are concerned, however, there is no reliable endocrine treatment for sterility except in cases of adrenal disease of a particular type (hyperplasia—an overgrowth of a tissue or organ), and here the use of adrenal cortical hormone may be curative. Russell Ramon de Alvarez has summarized the fantasies about sterility and, in this connection, warns against expecting results—except in such cases as mentioned above—from endocrine therapy. (See *Hormones and Behavior*)

What treatments are available for sterility? How successful are they?

One very good treatment for sterility is a thorough premarital examination. Of course this is preventive treatment, but if there are physical conditions or emotional conflicts that will make pregnancy difficult or impossible, the prospective husband and wife should face and deal with them as soon as possible. The most beneficial result may be educational; complete and accurate knowledge about sexual intercourse and conception will often foster positive and confident attitudes that lessen the chances of sterility. (See *Sexual Relations and Marriage; Conception, Pregnancy, and Childbirth*)

Another excellent treatment for sterility is to face up to the problem and decide to do something about it. In an astonishing number of cases, pregnancy follows making the appointment with a gynecologist or clinic or occurs during the medical "work-up" itself. As with adoption or the decision to adopt, simple acceptance of the problem and doing something about it may be enough. In such cases, of course, psychological factors have been the important ones preventing conception.

Of all couples coming to sterility clinics, from 25 to 35 per cent

eventually become fertile. In one large series, the causes of sterility were physical in about 40 per cent of the cases, psychological (including honest ignorance) in about 30 per cent, and a mixture in about 30 per cent. Of the total, 27 per cent achieved pregnancy—80 per cent of these within one year, and 100 per cent within four years. It is therefore worth seeking treatment. In some cases, the cure will be spontaneous; in others, there will be no cure. Whatever the outcome, it is best to face the problem early and let the diagnostic chips fall where they may.

What percentage of divorces is caused by the sterility of one of the partners?

Sterility is not a legal cause for divorce in the United States, and it is, therefore, impossible to know how often it is the actual cause. Divorces on the grounds of adultery, cruelty, incompatibility, or abandonment may, of course, have sterility as the "real" cause. When sterility does lead to divorce, the reasons are as diverse as the reasons for wanting children.

Based on current research and other studies, what might be predicted about the prevalence and treatment of sterility in the future?

There are reasons for restrained optimism. Assuming a 10 per cent sterility rate now, we know that 25 to 30 per cent can be cured if they seek medical help. Wider dissemination of these facts combined with increased availability of specialists and clinics for the treatment of infertility will combine to reach a greater number of those who can be helped. There is, however, no present indication of striking new medical or surgical treatments in this field. Indeed, there has been little progress in the past twenty-five years except, perhaps, in the areas of enlightenment, encouragement, and other psychotherapeutic measures. Nevertheless, scientific evaluation of present-day methods and results, and continuing efforts to perfect new medical and surgical measures will certainly bring new advances just as they have in other fields of medicine.

STERILIZATION, EUGENIC

by ELYCE H. ZENOFF, LL.B.

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What is eugenic sterilization?

Sterilization is a surgical procedure which deprives men and women of the ability to have children. The standard method used to sterilize males is called a vasectomy and the method used for females is called a salpingectomy. Neither method is hazardous under modern surgical conditions.

The purpose of eugenic sterilization is to prevent procreation by persons who, it is believed, may produce abnormal children.

The term *eugenics* is derived from a Greek word meaning "well-born." In 1883, Sir Francis Galton defined it as the study of the measures under social control that may improve or impair the physical and mental health of future generations. In 1908, he officially launched the eugenics movement, which had a twofold aim: (1) Positive eugenics—encouragement of the propagation of the biologically fit; (2) negative eugenics—discouragement of the reproduction of inferior stock.

During this same period, the laws of heredity formulated by the Austrian monk, Gregor Mendel, neglected since their publication forty years earlier, were rediscovered. These laws stated that character traits are inherited according to a definite ratio. Although Mendel's work had been confined to plant life, the eugenicists concluded that it was applicable to human beings. They decided that mental illness, mental deficiency, epilepsy, criminality, pauperism, and various other defects were hereditary. Support for this view led to considerable agitation for corrective action. Since attempts at cure for hereditary defects were considered futile, preventive measures appeared to be the only way of eliminating those defects.

To whom do eugenic sterilization laws apply?

These laws apply to the mentally ill, mentally deficient, epileptics, "hereditary criminals," and sexual deviates. However, 95 per cent of all reported sterilizations have been performed on mentally ill or mentally deficient persons. Although many persons believe that most sterilizations are performed on the mentally deficient, as of January 1, 1960, the

total of those who had been sterilized included 27,436 mentally ill persons and 31,931 mentally deficient persons.

What is the historical background of eugenic sterilization legislation?

The legislative history of eugenic sterilization began in 1897 when a bill for its authorization was introduced in the state of Michigan. The bill was defeated. Eight years later, Pennsylvania's legislature became the first state legislature to pass a eugenic sterilization bill, which was titled "An Act for the Prevention of Idiocy." The governor vetoed it with a message which said in part:

"If idiocy could be prevented by an Act of Assembly, we may be quite sure that such an act would have long been passed and approved in this state."

Two years later, in 1907, Indiana enacted the first sterilization law, but this statute was declared unconstitutional as were all similar laws in other states which came before the courts prior to 1925.

Some of the proponents of eugenic sterilization were so zealous that they began sterilizing people before there was legislative authority for such activity. E. S. Gosney and Paul Popenoe reported in *Sterilization for Human Betterment* that from 600 to 700 boys were sterilized at the Indiana reformatory, before the adoption of the Indiana act.

By 1921, almost 4,000 operations for eugenic sterilization had been performed. More than 20 per cent of these operations were performed without any statutory authority or under statutes which were subsequently declared unconstitutional. The remainder of these sterilizations were carried out under laws whose constitutionality had never been tested. More than 80 per cent of these operations were performed on mentally ill persons.

The constitutionality of eugenic sterilization was first established in 1925 by the Supreme Court of Michigan in the case of *Smith vs. Command*. A few months later the Supreme Court of Appeals of Virginia, in *Buck vs. Bell*, held that Virginia's sterilization law was valid under the state and federal constitutions. An appeal from this decision was taken to the United States Supreme Court. In 1927, in a brief opinion, which is probably best remembered for Justice Oliver Wendell Holmes's comment, "Three generations of imbeciles are enough," the court held that the law was a reasonable exercise of the police power and did not violate either the due process clause or the equal protection clause of the Fourteenth Amendment.

How many states have eugenic sterilization laws?

Twenty-eight states have eugenic sterilization laws, twenty-six of which provide for compulsory sterilization. (*Voluntary*: Minnesota, Vermont; *Compulsory*: Alabama, Arizona, California, Connecticut, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Maine, Michigan, Mississippi, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Virginia, West Virginia, and Wisconsin.)

The laws apply to both the mentally ill and the mentally deficient, except in Alabama and Nebraska, where they are limited to the mentally deficient. Nineteen states have laws which apply only to persons confined in hospitals or institutions caring for those afflicted with the conditions specified in the law; the remaining states have laws which apply also to persons who are not confined.

What is the most common legal requirement for the issuance of a sterilization order?

The most common statutory language is: "According to the laws of heredity, the person is the probable potential parent of socially inadequate offspring likewise afflicted."

Has the patient or the patient's family the right to refuse to permit eugenic sterilization?

Under compulsory sterilization laws neither the consent of the patient nor the consent of his family is required. In most states, the patient, a relative, or a guardian must be notified of the proposed sterilization. The minimum period required for notice varies from ten to thirty days. Usually there are provisions for a hearing and judicial appeal. However, five states do not require a hearing, and four make no provision for a judicial appeal from the hearing.

What is the layman's view of eugenic sterilization?

We do not know what the layman's view is toward compulsory or voluntary eugenic sterilization. However, inasmuch as many lawyers and physicians are not aware of the existence and provisions of involuntary sterilization legislation which applies to the mentally ill and the mentally deficient, it is probable that laymen are also lacking in knowledge of the situation.

What is the theological attitude toward eugenic sterilization?

The Catholic Church's opposition to eugenic sterilization was stated by Pope Pius XI in 1930, in an encyclical letter. According to

Rabbi Emanuel Rackman, former president of the New York Board of Rabbis, Judaism is opposed to eugenic sterilization. The official position of the various Protestant denominations is not known.

What is the scientific attitude toward eugenic sterilization?

There is not unanimous agreement among scientists concerning the benefits of eugenic sterilization. The main arguments of the proponents of sterilization are as follows:

- a) Mental illness, mental deficiency, epilepsy, pauperism, and certain forms of criminality are increasing.
- b) Persons with these conditions have more children than the normal population has.
- c) These conditions are hereditary.
- d) Environment is of less importance than heredity in the creation of these conditions.

However, studies undertaken since 1935 have thrown substantial doubt upon these arguments. The most important study, conducted by the American Neurological Association's Committee for the Investigation of Eugenical Sterilization, concluded:

- a) There is nothing to indicate that mental disease and mental defect are increasing.
- b) The high birthrate of the mental defectives is a myth.
- c) Considering the present knowledge of heredity, sterilization should be voluntary rather than compulsory.
- d) Environment is as potent as heredity in the development of conditions (listed above), and in many instances is even more effective than heredity.

Another example of scientific opinion concerning eugenic sterilization was a recent report by the Mental Health Committee of the South Dakota Medical Association. It advocated that compulsory sterilization should be eliminated in the field of mental illness since "medical science has by no means established that heredity is a factor in the development of mental disease with the possible exception of a very few and rare disorders."

What is the legal view of eugenic sterilization legislation?

There are two legal viewpoints concerning the constitutionality of eugenic sterilization laws.

The first theory is that the constitutionality of sterilization laws depends upon their scientific validity. Many advocates of this view believe that the scientific premises upon which the statutes rest are erroneous

and consequently that compulsory sterilization is an arbitrary and unreasonable deprivation of liberty.

The second theory, which has been growing in popularity, is that the right to bear children is a fundamental liberty that cannot be interfered with by government order. The supporters of this theory have strongly criticized the decision in *Buck vs. Bell*.

Is the number of eugenic sterilization operations increasing or decreasing?

The number of eugenic sterilizations has been steadily decreasing. For example, in 1949, the Human Betterment Association of America reported state totals of sterilization operations at 1500. In 1959, the association reported state totals of only 614. No sterilization laws were repealed during this period. It is not known whether this trend away from eugenic sterilization stems from doubts concerning the constitutionality of the laws, a change in medical opinion concerning their usefulness, public disapproval, or any combination of these factors.

What might be predicted about the future of eugenic sterilization laws?

Recent scientific studies have thrown considerable doubt upon the usefulness of eugenic sterilization laws. In addition, legal scholars have increasingly questioned their constitutionality, aside from whether or not scientific studies could demonstrate that the laws are effective in reducing mental disability.

A few years ago at a symposium on "Morals, Medicine, and the Law," Harry Kalven of the University of Chicago Law School suggested that in the near future "three generations of imbeciles may no longer be the prediction and even where it is, it may no longer be enough" to justify the existence of eugenic sterilization laws. Kalven went on to say that "*Buck vs. Bell* may in the end serve as a monument only to the wit but not the wisdom of Mr. Justice Holmes."

STRESS

by SHELDON J. KORCHIN, P.H.D.
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What is stress?

Stress, originally a concept of the physical sciences, has come into common usage in the biological and human sciences to describe a state in which the vital functioning of the organism is threatened. In physics, stress is a force—exerted on a system—that deforms, destroys, or alters the structure of that system, and the resulting change is termed strain. The general connotation of stress has remained, though without this precise distinction. Stress involves a sufficiently potent danger to psychological or physical well-being as to require extraordinary measures for the maintenance of organized behavior or, these failing, stress may lead to disordered behavior, anxiety, or other emotional disturbance. Theoretical examination of parallels in stress-defense-breakdown processes at all levels of biological, psychological, and social functioning has aided greatly in conceptualizing the stress issues of particular pertinence to mental health. Of particular concern for students of personality and psychopathology are conditions in which the integrity of the ego (the individual's self-esteem and capacity for self-regulating behavior) is threatened and whose consequences might be seen in emotional disturbance.

How do physical and psychological stress differ?

Physical stress, emotional stress, social stress, and similar phrases are often used to describe different loci of threat to organismic well-being. Though all have in common the potential for destroying ordered behavior by overtaxing adaptive capacities, they act at different levels of functioning. Thus, extreme cold requires extreme adjustments of the body's temperature-regulating mechanisms, as severe frustration of a psychologically important need requires extreme ego-defensive activity. But often the same condition may be doubly stressful, or stressful in one realm but not another. Fasting is both a metabolic and psychological stress; if the hungry man fears death, he may perhaps even view the hunger as punishment for sin. Hunger voluntarily undertaken

as a religious observance or in political protest (or even in pursuit of a svelte figure), however, may have similar metabolic effects but results in proud satisfaction rather than anxiety. Despite specific stress-response mechanisms, there are also general reactions that make it difficult to distinguish one from another order of stress conditions simply in terms of the response evoked. Physical danger, a painful stimulus, or a social *faux pas* may all lead to increased heart rate, more rapid breathing, elevated blood pressure, and similar physiological reactions. Indeed, the generality of such response has provided a valuable tool for the psychological study of stress as well as for the application of this response in ways such as lie detection.

What are some kinds of psychological stress?

Any situation that makes difficult, or encourages failure of, directed activity can be psychologically stressful. This would include such everyday experiences as distraction, noise, difficult problems, lack of sufficient time, facilities, or skills for solution, competition, or social pressure. Indeed, many of these have been used in laboratory research to create and study temporary disturbance and its behavioral and emotional consequences.

Commonly, the term "stress" is applied to the stimulus or condition acting upon the individual, where properly it should be used to describe a total state including stimulus aspects, the person's motivation and values, and the consequent responses. For an accomplished mountain climber, scaling the Matterhorn may involve little physical stress; for the present writer, it would be stress of the highest order. However, failure to reach the peak might depress the expert, but not at all trouble the writer, whose self-esteem is not dependent on scaling mountain peaks. It is clear, therefore, that the extent of potential disturbance depends on the importance of the activity and the centrality and strength of the need motivating it.

Of particular importance in the understanding of mental health are conditions of conflict and frustration, in which either two or more antagonistic needs are simultaneously aroused or where some internal or external barrier thwarts the satisfaction of a need.

What are the major psychological reactions to stress?

Stress reactions are of three distinct sorts—defensive, adaptive, or disorganized. The stress situation evokes mechanisms that protect the person's well-being by mitigating or reducing the impact of the stress.

These are called ego-defensive mechanisms. With these are actions that facilitate the achieving of some goals despite the stress situation. Saul Rosenzweig called these actions "need-persistent" mechanisms. Lastly, there are the reactions that reflect the disorganization or disturbance of behavior that occurs if adaptive or defensive activities fail. These include anxiety, depression, rage, and other evidences of strong and uncontrollable emotion, as well as more primitive and ineffectual behavior, such as lessened ability to remember, to learn, to judge clearly, and the like.

Disturbance is most likely to occur when stress is intense and long-lived and when defensive and adaptive mechanisms are weak or their capacity is exceeded. Under other conditions, stress may lead to more effective functioning. Though seemingly paradoxical, stress may lead first to improvement in performance and only if increased beyond some critical point may lead to subsequent deterioration. The student who fails an examination may study harder and more effectively, but further failures may lead to anxiety, ineffective studying, resignation, and eventually greater failure.

Stress reactions may be delayed as well as immediate. In wartime studies, Roy R. Grinker and John P. Spiegel found that some soldiers had more intensive anxiety reactions after returning from the combat zone than when in actual danger. Similarly, Harold Basowitz, Harold Persky, Grinker, and the present writer found increased anxiety and other psychological and physiological symptoms *after* men had successfully completed a program of paratrooper training. The defensive processes allow successful performance during the acute stress, and only with their later relaxation does the blocked disturbance appear. Such capacity for delaying disturbed reactions has great adaptive value.

What are defense mechanisms?

Although the germinal idea appeared early in Sigmund Freud's thinking, it was mainly in his book, *The Problem of Anxiety*, and in the later work of Anna Freud and others, that the concept of defense mechanisms was developed. These are techniques, operating unconsciously, that reduce the threat to the integrity of the ego, either by denying its existence, altering its meaning, diverting its emotional impact, or other intrapsychic maneuvers, thus minimizing potential anxiety. With this concept, a new view of neurosis emerged in which the neurotic symptom is understood in terms of the fixation of defensive mechanisms beyond their emergency function. Terms like repres-

sion, rationalization, denial, projection, and intellectualization are familiar examples of the many types of defense behaviors that have been cataloged. For the psychologically healthy individual these serve to reduce acute distress and to facilitate adaptive behavior in emergencies. In the neurotic, their continued overuse leads to crippling side effects.

Though ranging from relatively harmless to more incapacitating in their secondary effects, all defenses involve some restriction of normal functioning and hence potentially negative consequences. To deny one's inadequacies may provide comfort at a particular moment, but may encourage further unrealistic goals, hence further failure and denial, until perhaps a point is reached where inadequacy can no longer be denied or the consequences of failure are too destructive.

The particular defense used is a function of the nature of the stress, and what behavior is possible in the situation, and of the defense "repertory" of the person. Defenses, like other aspects of the enduring personality organization, are learned behaviors developed in the history of the individual's stress experiences. (See *Mental Mechanisms*)

How are stress and anxiety related?

Anxiety is the most important among emotional stress reactions. It occurs when the psychological threat is sufficiently intense and enduring, and/or where defenses are insufficiently strong to deal with it. Although it is clear that there may be considerable stress, and consequently altered behavior, without visible anxiety, anxiety is conceived as the prime marker of stress-induced disturbance.

As an emotional state, anxiety is the painful experience of dread and foreboding; it seems unrelated to definite objects and is of vague origin and unpredictable termination. In extreme, it is terror and panic; in lesser intensity, vague apprehension or tension.

Freud was the first to suggest the dual role of anxiety in stress. As a *signal* of impending danger, anxiety serves to mobilize defensive and adaptive mechanisms. But these failing, anxiety in more intense and crippling form is the *symptom* of the disorganized state. Just as physical pain leads to withdrawal from the painful stimulus, some anxiety serves as protection from further incapacitating anxiety. (See *Anxiety*)

Is a certain amount of stress desirable?

The most effective functioning occurs at an optimum, not a minimum, level of stress. If we were never challenged to our full capaci-

ties, if we could satisfy our needs at will and work at our own pace, it is questionable whether we would be happier, and we certainly would be less effective and creative. Psychologically healthy persons seek challenge and excitement and prefer to deal with (manageable) stress. Similarly, in the development of the personality, the experiencing of some stress leads to the strengthening of resistance and defenses. If one could anticipate and satisfy all the needs of an infant so that he need never cry for food or love or know the discomfort of wet diapers, one would produce an adult unable to deal with normally occurring stress at times when frustration is inevitable. For this reason, overly permissive child rearing, just as overly harsh, produces less than optimal mental health.

Is minimal stimulation stressful?

Recent findings have shown that individuals under conditions of greatly reduced environmental stimulation can become profoundly disturbed. Volunteers kept in lightproof, soundproof rooms over a number of days were often found to become anxious, to hallucinate, to become apathetic, and to function poorly even after release. The human organism needs some level of stimulatory input, both in early development of the intellectual capacities and in later life, to maintain adequate functioning. Just as excessive stimulation can be stressful, so too is a considerable reduction of stimulation stressful. (See *Sensory Isolation*)

What is the relation between stress and bodily functioning?

Under stress a complex series of physiological processes, under nervous and hormonal regulation, are triggered off. Of particular importance is the role of the pituitary-adrenocortical system, described in detail by Hans Selye. The pituitary gland releases A.C.T.H., activating the adrenal cortex whose hormones in turn alter many metabolic processes of importance in physiological functioning and biological survival. So too, the autonomic nervous system and the hormones of the adrenal medulla induce many peripheral changes familiar to us as symptoms of excitement and anxiety—quickenings of the pulse, flushing or blanching, rapid breathing, elevated blood pressure, sweating, and the like. Walter Cannon described these physiological stress reactions as preparatory to “fight or flight.” (See *Fear*)

Continued activation of physiological stress reactions—without the outlets available to our Stone Age ancestors—is an important factor in

psychosomatic disease, although many workers doubt the quite specific linkages between particular emotional conflicts and particular somatic complaints proposed by Franz Alexander and his colleagues. When angry, blood pressure normally rises. If rage is chronic, and suppressed for fear of retaliation or other reasons, essential hypertension could ensue.

How does psychological functioning change under stress?

At lower levels of stress, vigilance and alertness are increased, and performance is often facilitated. Reaction is quicker and more certain, perception more discriminating, learning and memory more effective. At more intense levels, or where coping mechanisms are weaker, psychological performance deteriorates. Precise motor skills are impaired, discrimination and judgment are more inaccurate, learning (particularly for novel or complex material) is slower, memory (more for new than for old learning) is less efficient, and intellectual problem solving is less effective. Considerable data, gathered in studies of anxious patients and normals in life and in laboratory stress experiments, show that the extent and variety of such changes depend not only on the nature and intensity of the stress but on such factors as the novelty and complexity of the task, presence of competing response tendencies, previous experience with similar tasks, and the like. But overall, behavior under stress tends, as Kurt Lewin once pointed out, to become more primitive.

Do people differ in their stress resistance?

G. L. Freeman once spoke of a "psychiatric Plimsoll mark" to describe the considerable individual differences in ability to sustain stress without breakdown, comparing it to the mark or line made on a ship's hull to indicate the point of safe submergence in loading the ship. The psychiatric Plimsoll mark varies with the nature of the stress and with temporary states, such as fatigue and illness. But it is a more or less enduring quality of the person, related to such factors as ego strength, self-esteem, and a minimum of unresolved emotional conflicts, which in turn reflect the earlier success of stress adaptations. One way of describing a mentally healthy person is in terms of a high order of stress resistance. Health, mental or physical, involves not only functioning adequately in general but also the capacity to maintain effective functioning under stress.

Perhaps "everyone has his limits," and sufficiently intense and en-

during stress may result in breakdown in almost any human. But, more remarkable is the great resilience possible under extreme duress, as Bruno Bettelheim's accounts of his own and fellow concentration camp inmates' experiences attest.

Is extreme stress a major factor in mental disease?

This is difficult to answer categorically. Certainly, under extreme stress of combat or disaster many have required psychiatric treatment (though others with the same experience did not). Moreover, wartime psychiatric studies of Grinker and Spiegel showed that breakdown more commonly occurred where combat stress was coupled with preexisting personality weaknesses. As noted, the early history of stress adaptation and the resulting ego competence or weakness is of major importance in understanding later stress resistance and mental health.

However, there is no substantial evidence that severely disturbed psychiatric patients (psychotics) have in general more traumatic histories. Contrariwise, many persons who have suffered great stress remain mentally healthy. We are far from knowing what causes major mental illnesses, but some of the causes undoubtedly are involved with important constitutional and physiological factors and critically important early psychological experiences, which cannot properly be called stress.

What are the stresses of present-day society?

Social critics call this an "Age of Anxiety." With tremendous advances in industrialization, urbanization, communication technology, and science, the pace and complexity of social life have multiplied rapidly. Paradoxically, the same forces that conquered the ignorance, disease, and privation of earlier times have created new stress in the modern era. At the same time, the stress-adaptive mechanisms—the biological, psychological, and social in differing degree—lag behind the new demands made on them.

For individuals or for societies, periods of rapid change tax older modes of behavior that no longer properly fit new challenges. Thus, for example, movement of population necessitated by industrialization and urbanization strains the traditional family organization and roles. The grandparents are cut off from the emotional and economic support of their children (meanwhile being kept alive longer by medical advances). The parents lose the skills and knowledge of their parents, while having to deal afresh with the problems of their children, who in

turn lack the emotional acceptance and guidance of the extended family and instead have to seek status and achievement in their peer groups. Though by no means simply related, current social problems such as divorce, juvenile delinquency, and proper care of the aged reflect the trend from traditional family solidarity. (See *Mobility and Mental Health*)

Because it is easier to apply traditional solutions than to create new ones, anxiety often accompanies mobility and social change. So too, extended personal and economic freedom can lead to confusion and conflict as well as to greater personal fulfillment. Thus, the woman who proceeded into an arranged marriage and a guaranteed job as wife and mother at least was free from the uncertainties of choosing suitors (and of being chosen), of the competing attractions of career and home, of deciding who does what in husband-wife interaction, and of other stresses facing "today's woman," though she lacked the potentially more profound satisfactions of self-determination. Opportunity for social advancement and economic betterment have fostered achieving, competitive and acquisitive needs, and the corresponding risks of failure and frustration, not known in more stable and rigid societies.

Thus, many of the stresses of modern social life are by-products of social progress. It is futile to wonder if life would be better if the "good old days" could be restored, for society can no more retrace its history than an individual can regain the pleasures of childhood without losing the achievements of adulthood. More important is the question of whether new values and institutions can evolve that will permit not only greater freedom from stress but also greater opportunity for harmonious and creative living. (See *Morals, Values, and Mental Health*; *Social Change and Mental Health*; *Social Factors in Mental Illness*; *Social Status and Mental Health*; *Optimum Mental Health*)

SUICIDE

by PAUL FRIEDMAN, PH.D., M.D.
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How many persons commit suicide each year in the United States?

In recent years the suicide rate in the United States has averaged approximately ten persons per 100,000 of population per year. This means that one person out of every 10,000 died by suicide. In 1958, the most recent year for which the data were available, the rate was actually somewhat higher and the number of reported suicides was 18,400. These figures refer to actual suicides only. No precise statistics are available on suicidal attempts that do not result in death.

How do these figures compare with those of a generation or two ago?

The current suicide rate in the United States is approximately the same as it was at the beginning of the century. On the other hand, it is much lower than during some intervening periods. The rate rose rather sharply after 1900 and remained at a relatively high level from 1910 to 1915. Beginning with 1915, there was a sharp decline until 1920, then an almost steady rise, which continued into the 1930's. The current rate is considerably lower than that for the 1930's, but the indications are that it is again on the rise.

How does the rate of suicide in the United States compare with the suicide rates of other countries?

It occupies an intermediate position. According to the figures given for 1958 by the World Health Organization, the rates for Austria, Denmark, Finland, (Western) Germany, Hungary, Japan, Sweden, and Switzerland are approximately twice as high as the rate for the United States. The French suicide rate, although lower than the rates for these countries, is also substantially above the United States rate. For England and Wales the rate is but slightly higher than for the United States. On the other hand, the rates for Canada, Iceland, Italy, the Netherlands, Norway, Portugal, Scotland, and Spain are all somewhat lower than the United States rate, and those of the Republic of Ireland, Northern Ireland, Costa Rica, Greece, Guatemala, Mexico, and Nicaragua, for example, range considerably below it. The Mexican

rate (only about one-fifth of the United States rate) is the lowest, and the rate for Japan ranks highest on this scale.

Does the rate of suicide in the United States fluctuate according to periods of economic depression?

Yes, to some extent it does. However, the relationship between the suicide rate and the economic cycle is by no means a simple one, as is demonstrated by the fact, among others, that in the United States the rate of suicide is relatively high in groups of higher economic status.

Does the degree of a country's economic well-being affect its suicide rate?

There is no clear-cut relationship between them. For instance, in Europe the suicide rate is relatively high in Austria, Denmark, (Western) Germany, Sweden, and Switzerland, and is relatively low in Greece and in Ireland, but this difference cannot be explained in economic terms.

Does a country such as Japan, where suicide is considered to have an honorable aspect, have a correspondingly higher rate of suicide?

Yes, it does. The data for 1956, 1957, and 1958 indicate that Japan still has a higher suicide rate than most other countries despite the fact that since the end of World War II the traditional Japanese attitude toward suicide no longer has official endorsement.

Is the suicide rate relatively low in countries where there is a strong religious or moral condemnation of suicide?

Generally, yes. The Catholic religion is especially strong in its condemnation of suicide, and the suicide rate tends to be low in Catholic countries. However, there are exceptions; for instance, Austria.

Are there some societies in which suicide is unknown?

Some anthropological reports indicated that the aborigines of western and central Australia, the Caroline Islanders, the Kafirs in India, and the Yahgans of Tierra del Fuego were unfamiliar with suicide. However, much of the information on this point came from early anthropologists, some of whom were not very reliable observers.

Does war affect the rate of suicide among civilians?

Sociological studies indicate that suicide among civilians decreases sharply in times of war. The focusing of aggressive feelings on the enemy is believed to be an important factor in this phenomenon. By contrast, in periods of social disorganization following a war there is often a considerable increase in the number of suicides.

Can it be said that lower animals commit suicide?

True suicidal intent, as we understand it, presupposes a mental concept of suicide. We have no evidence that such a concept exists in animals. Instances of animal suicide have often been reported, but none of them have been authenticated. If an animal seems to behave so as to bring about its own death, this can usually be explained by reflex action, sometimes by accident, and sometimes by simple facts unknown to the observer. Certain legends, which persist even though they have long been disproved, have taken hold in the popular imagination. A case in point is the "suicide" of the scorpion when it is ringed by fire. Its venom has no effect upon itself or upon others of its species, but scorpions are lethally affected by the heat of a fire or sunshine, and convulsive contraction of the muscles might appear to bend the stinger back to the dying creature's own body.

Can a valid distinction be made between "genuine" and "pseudo" attempts at suicide?

Such a distinction is unscientific and misleading. Some persons may have no conscious intention of ending their lives but use the suicidal act as a means to influence the environment in their favor. However, since there might always be an unconscious motivation for the act, the term "pseudo" attempt is psychologically incorrect. The physical outcome of a suicidal act (death or survival) does not always prove serious intention or the lack of it.

Do more men than women commit suicide?

The number of attempted suicides is greater among women; however, the number of deaths from suicide is greater among men.

Is there any relationship between age and the number of suicides?

Yes. The death rates from suicide increase sharply with age. This increase, however, is considerably more marked among men than among women.

Are there certain professions or vocations in which the suicide rate is high?

Yes. Suicide rates are higher in some occupational groups than in others. According to some British statistics, as reported by Louis I. Dublin and Bessie Bunzel, physicians, dentists, and lawyers topped the list. Among others who showed a high incidence of suicide were auctioneers, appraisers, traveling salesmen, insurance agents, bank clerks, and farm owners and their relatives. Exceptionally low mortality by suicide was found, for instance, in railroad workers, bargemen and boatmen, civil servants, and among building trades workers. American statistics reflect a similar picture, when allowance is made for regional and cultural variations. The clearest overall trend that emerges from these comparative studies is higher incidence of suicide at higher educational levels. In the armed services, for example, the suicide rates tend to be higher for officers than for enlisted men. An exception is the low rate among clergymen, primarily due, no doubt, to the religious injunctions against suicide. The conspicuously high rates of suicide among physicians, pharmacists, and chemists may have something to do with the fact that the members of these professions have readiest access to lethal drugs.

What are the factors to which suicides or suicide attempts have often been attributed?

Suicides and suicide attempts frequently are attributed to such factors as ill health, physical pain, incurable disease, loneliness, unrequited love, sexual betrayal, loss of wealth or status, pessimism about one's future, or the imminent revelation of a shameful act. But these reasons very often are merely precipitating factors. Obviously, many more people undergo such suffering and affliction without ever attempting suicide. The desire to live is very strong, even in most incurably ill patients; they usually have an unconscious tendency to deny their imminent danger.

Why are some suicides committed for reasons that seem quite trifling and transitory?

We sometimes hear of young people who committed suicide for no graver reason, apparently, than a poor mark in school or an embarrassment at a party. We also hear about cases where suicide supposedly resulted from a momentary weariness or a feeling of unwillingness to take up the burden of living just one more day.

But usually the real cause of the suicidal act lies considerably deeper than the trivial or transitory reason given for it. Clinical evidence indicates that such suicides are often the result of an overwhelming rush of hostility against someone else and are acts of punishment or revenge. By killing himself the individual may seek to arouse sympathy, remorse, and bitter feelings of guilt in the other person. Hostility against the parents (or against one of the parents) often plays an especially important role in the suicides of young people. The poor mark at school or the embarrassment at a party may be merely a trigger that sets off this hostility.

Is the availability of a weapon or a method a factor in suicide?

The presence of a weapon or the immediate availability of a method undoubtedly often plays a role; it may offer instant means to act on a strong suicidal impulse. However, a person who has reached a firm decision to commit suicide usually has within his reach some means of carrying it out.

Has the choice of method any significance?

Generally speaking, methods of self-destruction may be divided into two broad groups: passive and active. One may describe as passive: turning on the gas, swallowing pills, drowning, etc., which are methods preponderantly chosen by women. Shooting, for instance, is an active and violent method used mostly by men.

Moreover, the method employed in a suicidal act often has a specific, symbolic meaning. For example, when suicide is committed by drowning, we may infer that fantasies of rebirth played an important unconscious role. An individual for whom a particular suicide method has such a specific meaning will rarely resort to any other method. If a person chooses a particularly painful way of dying, he probably had a deep-seated need for punishment. Violent modes of suicide by various devices are no longer invariably regarded as haphazard actions due to delusional psychotic outbursts. Psychoanalytic findings have revealed that they, too, may have symbolic meanings.

Can "accidental" deaths result from an unconscious desire to die?

Yes. An apparently accidental overdose of medication, an apparently thoughtless running out into traffic, an "accidental" fall from a high place, all can be due to unconscious death wishes. We also know that persons with suicidal tendencies sometimes adopt occu-

pations or sports, such as acrobatics or stunt flying, in which the risk of death is relatively high.

Proneness to accidents is a definite sign of unconscious self-destructive motivations. Repeated accidents usually represent an unconscious need for atonement or expiation. These sacrificial symbolic acts momentarily appease the guilty conscience, until the recurring inner tensions again press for a repetition.

What is the connection between suicide and homicide?

The word suicide implies killing. In many instances a suicidal act follows after murder. Dynamic psychology looks upon suicide as a reversal of aggression originally directed toward the outer world. It is a psychoanalytic maxim that nobody kills himself who at some time did not wish to kill someone else. It is noteworthy that criminologists and sociologists of the nineteenth century discovered an inverse relationship between the rates of suicide and capital crime.

What is a suicide pact?

A suicide pact is an agreement between two persons to commit suicide together. They may decide that each shall kill himself, or that each shall kill the other, or that one shall kill first the other and then himself. In this latter instance, it may happen that the executor of the pact carries out the first act but fails in the second. Both from the legal and from the psychological standpoint the survivor can then be viewed as a murderer, even though he may have sincerely intended to take his own life as well. Unconscious motivations undoubtedly play a very great role. It is noteworthy that very often the instigator of such a pact is the one who remains alive.

What are the psychological implications of the game of Russian roulette?

In this superstitious gamble with death, the responsibility for suicide is shifted to a higher power—to destiny. This means that consciously the gambler will accept the verdict of chance: to die or to live. But even if he survives, the unconscious inner conflicts will persist.

If the game of Russian roulette is played in a group, it may have some of the characteristics of a suicide pact.

What is the explanation of "contagious" suicides?

The phenomenon of contagion is explained by two main factors: imitation and identification. Sometimes a suicide captures the imagination of other persons, leading to a whole series of suicides or suicidal attempts. Such suggestibility has been known to occur among students, soldiers, and other groups. It seems plausible to assume that such suicide waves are most likely to occur when the initial case activates self-destructive tendencies that might otherwise have remained dormant.

As for suicides running in families, they may be explained by unconscious identification rather than by hereditary factors. Identification means that certain attitudes, values, and patterns of behavior are developed through the child's imitation of his parents, whose characteristics may thus become integrated into his personality.

Can suicidal propensity be a factor in heroism?

Readiness to die for a cause may, sometimes, be fostered by deep suicidal fantasies. Wars, revolutions, etc., may offer opportunities, for persons with suicidal tendencies, to seek heroic death.

Is suicide a cowardly act?

Such a value judgment would not be scientific; it can be based only on religious, cultural, or individual opinions.

Is a person who contemplates suicide mentally ill?

Not necessarily. Most persons have suicidal thoughts at some time in their lives.

Is a person who commits suicide mentally ill?

The idea that suicidal acts are invariably a result of mental illness was abandoned long ago. Manifestly delusional or psychotic persons constitute only a small percentage of those who commit suicide. Although persons suffering from severe depressions show suicidal propensities, only a minority of them resort to suicide.

Are there any signs, observable to a trained person, indicating that an individual is likely to commit suicide?

There are such signs, but they are far from infallible. Anxiety states, depressions, overt suicidal threats, a history of past threats or attempts by the person or close members of the family: these constitute

serious warnings. Unconscious self-destructive impulses can be unveiled during psychotherapy. Projective psychological tests sometimes permit the detection of specific personality difficulties pointing to suicidal trends.

Although many people make suicidal threats without carrying them out, such threats should always be taken seriously.

What help exists for the individual who attempts suicide?

Aside from the treatment of bodily injuries, psychological investigation and diagnosis are imperative. If the risks of further suicidal attempts demand it, the patient may have to be hospitalized and kept under continuous surveillance. But custodial care alone will never prove sufficient; systematic and prolonged psychotherapy is indispensable to uncover and resolve the deep-seated, unconscious conflicts at the root of the suicidal impulse. Often an apparent improvement may be deceiving, and an early discharge is usually followed by another attempt at suicide. Many fatal suicides are committed by persons who leave the hospital against expert advice.

In treatment, can improper handling of problems or conflicts increase the possibility of suicide?

Yes, it can. A great danger may arise if, in psychotherapy, interpretations are offered too rapidly, before the patient is prepared for their emotional impact. Another danger might lie in a superficial and casual handling of matters that seem vitally important to the patient; this may prevent the establishment of the necessary positive transference (unconscious attachment to others of affectionate feelings and attitudes that were originally associated with important figures in one's early life) from patient to therapist.

Why is suicide held in contempt in our society?

The Judeo-Christian religions forbid suicide and condemn it as a sin. This accounts for the contempt with which it is regarded in our culture. A psychological source of such attitudes might be the unconscious fear of suicidal impulses in oneself.

What are some of the reactions and emotions that occur in the family after the suicide of a family member?

Feelings of guilt and remorse are the most common reactions. Close relatives usually reproach themselves for not having prevented

the suicidal act. In some instances these self-reproaches may have a degree of justification, but often they are greatly exaggerated. The guilt feelings may even become irrational, and in such cases psychological help is imperative.

Suicides in a family may have a far-reaching traumatic effect upon children. Identification with dead love objects is often an unconscious reason for suicide, especially in adolescence.

What may be the result of unfriendly community attitudes toward the family of a suicide?

Such attitudes tend to arouse and to exacerbate feelings of shame, guilt, and remorse, even when there is no objective reason for these feelings. By the same token, sympathetic and friendly attitudes will act as an antidote.

The enlightenment of the community about the nature and the deeper causes of suicide should be one of the most important goals of the mental health movement.

THE THERAPEUTIC COMMUNITY

by MAXWELL JONES, M.D.

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What is the therapeutic community?

The therapeutic community is a cooperative movement, within an institution or hospital, which is aimed at closing the communication gap between patient and staff for the benefit of all concerned. This movement recognizes that it is not enough for patients and staff to be able to talk freely within their own groups; that it is also desirable for patients to be able to talk freely with the staff and the staff with the patients.

In our middle-class culture, what is not expressed is often more important than what is considered legitimate conversation. The hospital setting affords the opportunity to develop a situation in which the communication of formerly unexpressed feelings and attitudes is encouraged for the betterment not only of the patients but also of the staff. Betterment here means the more appropriate use of professional skills and the opportunity for a mutual learning experience between patients and staff. Probably the setting most favorable in which this learning and treatment may occur is the community meeting.

What is the community meeting in the therapeutic community?

The community meeting is the daily meeting of all patients and staff and can be used in wards that have as many as sixty patients. Such a meeting affords an opportunity to examine the day-to-day problems of the patients and of the ward generally. Since a patient's behavior at a community meeting resembles the behavior that led to his being admitted to the hospital in the first place, the significance of this behavior can be examined in a positive way—this being impossible in the outside world where there is neither the setting nor the trained personnel.

At first, the patient finds it difficult to talk about topics other than

the usual conversational ones. In time, however, the patient realizes that much of his behavior can be understood only by examining his underlying motives. He finds that such examination can afford him considerable relief and often leads to more adequate ways of dealing with problems as well as to greater insight into his problems and behavior.

What are the aims of the therapeutic community?

Like all treatment methods, its aim is the betterment of the patient. However, the therapeutic community attempts to do this not only in terms of the two-person treatment relationship between patient and doctor but also by stressing the major importance of the patient's total environment of social factors that are involved in the development and abatement of mental illness.

What were the conditions prior to the concept of the therapeutic community that brought this theory into practice? How did these conditions affect the treatment, release, and rehabilitation of patients? How does this compare with results in the therapeutic community?

The lack of a sensitive awareness and concern about the physical and emotional setting in which patients lived, together with the stereotyped medical attitudes epitomized by "the doctor knows best," led to attempts to close the gap between patients and staff and to maximize the potentials for treatment and change in both groups. Pioneer educators such as Albert Deutsch played an important part in evolving this change.

These conditions, which existed up to recent years and indeed still are far too common, meant that patients could easily be harmed rather than helped by admission to a hospital. In the past, one of the great dangers has been the tendency to regard the patient as a passive recipient of a regimen of treatment and care. This has often led the patient to develop an attitude of overdependence toward the hospital, with the result that in many cases the patient has not felt any personal responsibility to participate. In the therapeutic community, however, the patients, in collaboration with the staff, become active participants in the therapy of other patients in community meetings and in other aspects of the overall hospital work. This helps the patients to become responsible members of the patient community and helps in their rehabilitation to the outside community. It is difficult to quote actual figures, but it is certainly true that this trend, along with the use of tranquilizing drugs, has contributed significantly to the consistent drop

in bed occupancy throughout the country despite the rising admission rate in hospitals.

How is the situation in the mental hospital or clinic different from that of yesterday? Physically? Emotionally? Socially? Medically?

Physically, the conditions remain much as before, but planning implies enormous changes in the whole physical organization of mental hospitals. The essential difference will be in the development of much smaller hospital units situated much closer to the communities they serve. Moreover, the inpatient population will, we hope, increasingly give way to people who are being treated in day hospitals, in night hostels, or in outpatient departments, preferably living at home wherever possible. In the interim, the large mental hospitals will probably begin to divide up into smaller semi-autonomous units, each serving a particular geographical area. This process has already begun in various parts of the country, the most famous example being the Dutchess County unit at the Hudson River State Hospital near Poughkeepsie, where Robert C. Hunt has made an outstanding contribution.

I think it is fair to say that the whole emotional climate in psychiatric hospitals is changing. The gap between staff and patients is narrowing. Moreover, this tendency, particularly among groups that aspire to something approaching a therapeutic community climate, means that the staff and patients are much more involved in the development of their own culture-atmosphere. This brings about a generally friendlier and more purposeful climate.

One hopes there will also be an increasingly close social relationship between patients and the outside community, particularly with their families. It is probably in this area that the most dramatic changes can be expected in the future, when patients will be helped to remain as "people," and never lose this identity. In the past, unfortunately, a mental patient was often thought of as loathsome and someone to be avoided at all costs.

Medically, one could say that psychiatric hospitals are tending more and more to develop their own atmosphere. This implies a moving away from the model of the general hospital. Many people feel that the traditional dress and behavior, which are appropriate in a general hospital, have little or no place in a psychiatric hospital and may, in fact, be antitherapeutic. For this reason, there is an increasing informality in mental hospitals, such as replacement of nurses' uniforms with everyday attire.

How does the therapeutic community function?

In order to develop a high degree of communication and treatment in the mental hospital, it is necessary to have frequent contact between all patients and staff in a treatment and training situation. This is probably best done by daily community meetings in a ward where current problems can be freely ventilated. Patients are encouraged to express their feelings in a way that is not usually acceptable in ordinary society. The airing of feelings is in itself often helpful and allows the group to become acquainted with each patient's underlying conflicts. One patient's problem frequently contains aspects familiar to other patients. Moreover, most patients' problems are related to their dealings with other people, and an examination of behavior may lead to more understanding, and result in more effective ways of behaving under stress.

Staff meetings immediately following the community meetings afford an excellent training opportunity. The doctor, social worker, nurse, psychologist, etc., each describes his differing perceptions of the same community meeting, and the underlying motivations in patient behavior can be examined. Moreover, the staff meeting affords an opportunity for the discussion of interpersonal problems within the staff and for an examination of roles, role relationships, and the overall culture of the treatment unit. Daily meetings of this kind lead to a much closer and more effective therapeutic team. Currently, the term, therapeutic community, can include the therapeutic role that is being developed with families and other social units, for example, the increasing use of home care instead of hospital care and the establishment of day hospitals with the patient sleeping at home.

What is the history of the therapeutic community?

It is difficult to establish definitive landmarks. It would be more accurate to think of the therapeutic community as reflecting the growth of social science skills and their application to psychiatry. The term therapeutic community probably was first used by Tom Main, Director of the Cassel Hospital near London, who described it in an article in the *Bulletin of the Menninger Clinic* in 1946.

Who were the most prominent contributors in this history?

In England, one would certainly think of the group of army psychiatrists associated with the Northfield Military Hospital near

Birmingham during World War II. Names such as W. R. Bion, S. H. Foulkes, Tom Main, and many others were associated with what came to be called the Northfield Experiment, which was an attempt to establish a therapeutic community in a large military hospital. At the same time, the developments at Mill Hill Hospital near London were taking a similar but quite independent line under the direction of W. S. Maclay, A. B. Stokes, and the writer.

Perhaps the most outstanding early examples in America were in the field of delinquency prior to World War II, where a number of important experiments were being carried out. The work of Fritz Redl and that of Bruno Bettelheim is outstanding. The application of therapeutic community principles to psychiatric hospital practice is associated particularly with the name of Harry A. Wilmer, who did some fascinating work at Oak Knoll Naval Hospital in Oakland, California.

Does the therapeutic community concept apply to all organized institutions?

There seems little doubt that many of the points previously raised could be applied to hospitals in general. For example, an annotation in a medical publication described how a random sampling of two hundred patients in a general hospital in Edinburgh, Scotland, revealed many criticisms of their hospital experience. The patients disliked rigid nursing routine, especially the early-morning bedpans. Most of all, the patients wanted greater flexibility in visiting regulations, including the number of visitors. Comments on medical care were directed at manner, rather than matter, with special pleas for more regular information on treatment and progress. Inadequate communication was indeed the major bone of contention, moving two out of three patients to express dissatisfaction. An analysis of the social situation is beneficial in almost any social institution, especially in factories, business firms, etc.

How many hospitals or institutions make use of the therapeutic community?

As yet, there is no analysis available that answers this question. There are many degrees of social development involved, and it would be difficult to get a consensus on which hospital could reasonably be regarded as practicing therapeutic community principles. Most psychiatric hospitals seem to be conscious of the need to develop along these lines and are in varying stages of transition.

Has the public attitude been changing toward the mental hospital and the patient? What has been responsible for this change?

There is reason to think that there has been an increasing awareness of the problems of the mental patient and a greater empathy on the part of the general public. One hopes that this is the result of education and of the interest shown by the mass media. Nevertheless, a great deal still remains to be done in this area. The stereotype of a mental patient as a "dangerous and unpredictable individual," all too frequently presented in the mass media, is in no way characteristic of the vast majority of mental hospital patients. This stereotype is being changed for the better as a result of the opening of hospitals to visits by the public. Firsthand acquaintance of high school and college students with the problems in mental hospitals, by frequent visits there, is a tremendous force in reducing prejudices.

How successful has this change been?

It is difficult to answer this in relation to public attitudes. However, Paul Leinkau, Professor of Public Health Administration at Johns Hopkins University, described a careful study of community attitudes in the Baltimore area. Comparing a recent study with studies done about 1950, he showed that the expert and the general public seem to have developed much more closely related ways of thinking about mental patients than heretofore.

What effect has the therapeutic community concept had on short-term mental hospital care?

I feel that any system which heightens the awareness of what is actually happening in a treatment community and allows the patients to express their feelings freely will have a considerable effect in lessening the dangers of "institutionalization" (a term used for unnecessarily long hospitalization resulting in overdependence on the hospital). The hospital should be looked on merely as a necessary adjunct to other forms of treatment.

What factors stand in the way of a successful therapeutic community?

The most important factor here is probably the attitude, training, and flexibility of the hospital superintendent. It is extremely difficult to develop a therapeutic community without positive approval of the institution's highest executive. The development of separate treatment teams, with partial or complete self-direction, means the emergence of

the problems associated with decentralization. Many superintendents feel insecure unless they are in complete control of the total hospital organization. It is the confident and imaginative superintendent who realizes, as in fact happens in big business, that decentralization into units of the most favorable size is a necessity, if communications and the feeling of identity are to be fostered. It is possible to be in contact with, and understand, only a relatively small group of patients. The optimal size for such a group has to be decided by many factors, but it is probable that hospitals should be divided into treatment teams, each to be concerned with fifty to one hundred patients. Smaller units might be preferable, but in most cases they would be economically impossible, at least in state hospitals.

Is there an organized campaign to spread the concept of the therapeutic community to institutions? What organizations are behind this? Do they offer training for personnel involved in the therapeutic community?

There is no organized campaign to spread the concept of the therapeutic community to institutions. Apart from the work of numerous individuals, the major impetus probably comes from the two big organizations concerned with group psychotherapy—the International Council of Group Psychotherapy, and the Moreno Institute. At present, training in this field can only be obtained in institutions practicing these principles, but no formalized training is as yet available.

What types of organization are working toward the establishment of the therapeutic community? What new techniques have been incorporated?

I would think that there is a trend toward therapeutic community methods in institutions generally, particularly in those where the thinking of social scientists has had some impact. This would apply to industry and to various kinds of correctional and therapeutic institutions. Particularly impressive, for example, is the work done in the California Department of Corrections, where two experimental therapeutic communities—one involving inmates within a large prison, the other involving inmates who are working in a forestry camp—are among the best I have seen. Psychiatric hospitals generally, including university clinics, state hospitals, and private institutions, are working increasingly toward therapeutic community concepts and practice.

Terms such as therapeutic community, milieu therapy, living groups,

etc., will become almost unnecessary, much in the way, one hopes, that terms such as psychosomatic medicine or rehabilitation, will no longer be necessary when training and attitudes have reached a more enlightened level.

It would seem that the ideas implicit in a therapeutic community are merely the commonsense application of social science knowledge and the humanities to the practice of psychiatry.

THE UNCONSCIOUS

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What is the unconscious?

The "unconscious," used as a noun, is the designation given by Sigmund Freud to a region of the mind comprising all mental functioning of which the person is unaware and which he cannot recognize or remember at will. It consists of mental events that have never reached consciousness and of those that were secondarily excluded from it (repressed) because they are objectionable to the subject.

The adjective, "unconscious," has various meanings. It may describe the state of a person who has lost his consciousness as the result of a severe head injury, or while fainting, or under the influence of a general anesthetic.

In a different meaning, "unconscious" applies to all mental events a person is "not conscious of" at a time when he may be fully conscious otherwise.

Unconscious mental activities may be either "preconscious," that is, only temporarily latent and subject to recall by minor effort, or "unconscious proper," which means that only specific and often laborious psychoanalytic techniques can bring them to consciousness.

Carl G. Jung distinguished two parts of the unconscious: the "personal unconscious," comprising all individual experience, and the "collective unconscious," containing inherited residues of the racial past, common to all men.

Why is it reasonable to assume the existence of an unconscious part of the mind?

Conscious awareness of events has many gaps. At any given moment we are conscious of only a part of our mental life, while most of it is in a state of latency, often for long periods of time.

We are forced to assume that mental activity goes on outside our

awareness because of many psychic phenomena, in healthy as well as in sick people, such as slips of the tongue, forgetting, dreams, the experience that ideas or solutions to problems come to us apparently from nowhere.

The assumption that there is an unconscious has proved to be extremely useful for the explanation of disconnected or otherwise unintelligible mental acts, of symptoms of emotional illness, and of the phenomena of hypnosis.

What is the difference between the unconscious and the subconscious?

Some authors use the term "subconscious" synonymously with unconscious. Freud preferred unconscious because it is more descriptive and lacks a pejorative undertone. Subconscious has become obsolete in scientific writings.

The Boston psychiatrist, Morton Prince (1854–1929), used subconscious or "coconscious" to describe additional personalities coexisting with a primary personality and becoming manifest under special circumstances. An example of such a "multiple personality" was described by Corbett H. Thigpen and H. M. Cleckley in their book, *The Three Faces of Eve*.

Who were the men prominent in the study of the unconscious?

Throughout the course of civilization poets, philosophers, and scientists have indicated in their works, with growing clarity and increasing frequency, their suspicion that unconscious mental processes affected human behavior significantly.

Current ideas on the unconscious were perhaps most clearly anticipated by the German philosophers Arthur Schopenhauer, Johann F. Herbart, Paul Carus, Eduard von Hartmann, and Friedrich Nietzsche.

In the late decades of the nineteenth century, French psychiatrists Ambroise Liebeault, Jean M. Charcot, and Hippolyte Bernheim prepared scientific approaches to the study of the unconscious by their exploration of hypnotism and hysteria.

Stimulated by their work Freud developed techniques that enabled him to demonstrate and to explore unconscious mental phenomena in a workable fashion. His observations have become the foundations for a growing body of psychological insights and psychotherapeutic procedures.

What is repression and resistance? How do these phenomena affect the exploration of the unconscious?

Freud noted that certain unacceptable or painful ideas, memories, or feelings are excluded from our consciousness. He called the process of exclusion, "repression." Repressed mental contents do not cease to exist after they have become unconscious. They continue to affect the manifest behavior and sometimes even reappear in a distorted form giving rise to emotional or pseudo-organic symptoms.

Psychoanalysts observed that everybody offers strong "resistance" to becoming aware of his repressed content. In psychoanalytic therapy, resistance is expressed by interference with the treatment procedure. Even the well-intentioned patient refuses to keep to his original promise that he will say at once everything that comes into his mind. He fights the analyst who confronts him with the unconscious meanings of his words and actions. However, as more and more converging evidence is brought to light by the patient, through the combined efforts of doctor and patient, the resistance is finally overcome, the repression is lifted, and "the unconscious becomes conscious." (See *Psychoanalysis*)

How are the id, the ego, and the superego related to the unconscious?

In his earlier theories, Freud explained neurotic symptoms as the outcome of a struggle between the conscious and unconscious parts of the mind. Objectionable mental content, according to these theories, is denied access to consciousness by a censoring agency. After repression, the objectionable content tries to reenter consciousness in one disguised form or another, thereby upsetting the person's emotional health. (See *Mental Mechanisms*)

Later Freud postulated that not only the repressed content is unconscious, but the repressing censoring agency as well. In other words, the neurotic conflict takes place between different parts of the unconscious.

This insight forced Freud to complement the original topographic model of the psychic apparatus (consciousness versus the unconscious) by a new "structural" point of view.

All psychic functions were part of three systems: the id, the superego, and the ego.

The id was designated the psychic representation of the biologic needs, that is, of the sexual and the aggressive drives.

The superego was defined as the internal representative of all moral precepts and ideal aspirations as they are transmitted via parents and other influences from the social and cultural environment.

The ego was designated to include all mechanisms regulating the individual's relations with the external world and preserving the person's unity in the cross-pressures of conflicting inner impulses and external tasks. (See *Ego*)

As a result of this structuring, the neurotic conflict was conceptualized to be between the ego and either the id or the superego.

With the exception of a part of the ego, all mental processes are within the unconscious. Unconscious content may, however, be transformed or translated into conscious content by the use of specific psychoanalytic techniques.

What are the functions of the unconscious? Is the unconscious always functioning?

To ensure optimal conditions for the life of an individual in an ever-changing physical and social environment, the central nervous system coordinates the various functions in all parts of the body continuously. Mental activities, the psychological correlates of central nervous system functions, must equally go on at all times. The degree of functioning depends on the state of the individual and his environment. Unconscious mental activities provide a continuous background to conscious experience. Whenever the functions of the ego are reduced, as in sleep or under conditions of emotional illness, unconscious mechanisms affect and distort ideation and manifest behavior to a greater degree. This gives dreams and emotionally disturbed behavior their "unreasonable character."

It must be stressed that irrationality is not always destructive or harmful to the individual. Imagination, creativity, and originality have their roots in the unconscious.

Do unconscious mental processes have special characteristics that distinguish them from conscious ones?

Some unconscious mental phenomena differ from conscious ones only in the respect that they are not conscious.

The id, psychic representative of our biologic drives, is governed by laws different from those familiar to us in waking thought. Its more primitive form of functioning is called the "primary process," as distinguished from the rational "secondary process" thinking found in the

mature ego. The primary process is characterized by a disregard for logic laws and logic categories of time and space, by a compelling push toward gratification without regard for realistic consequences, by conflict-free coexistence of opposite tendencies, by use of symbols and other mental mechanisms as found in dreams.

The greater irrationality, the restricted adaptability, and the reduced freedom of decision of immature or emotionally disturbed persons are thought to express the prevalence of the primary process in their thoughts and behavior.

How is the unconscious formed? Are all past experiences kept in the unconscious? If not, why are some experiences retained while others are not?

In what way and at what point of phylogenetic or ontogenetic development psychic processes first form is not known. It may be safely assumed that unconscious processes precede the development of consciousness. In the course of living, the boundaries between consciousness and the unconscious do not remain firm. Unconscious events become conscious, and repression pushes certain conscious experiences into the unconscious.

Freud assumed that all past experience is preserved in the unconscious. In the course of a psychoanalysis, emotionally significant memories often emerge in remarkable freshness, even after decades of repression. Old people often surprise us by suddenly recalling long-forgotten events from their earliest childhood. Yet it is probable that many emotionally insignificant data are permanently forgotten.

Why has it been found necessary to explore the unconscious?

The first reason is scientific curiosity. Neither healthy nor pathologic behavior can be understood without recognition of its dependence on unconscious mental events.

The second reason is psychotherapy. An individual without knowledge of important determinants of his behavior cannot reasonably change it. The person who becomes conscious of certain aspects of his unconscious gains a broader basis for his decisions and may increase the measure of his personal freedom and thereby his emotional health. The exploration of unconscious processes is an important aspect of some psychotherapies.

Third, man has gained technological powers that may enrich his

existence, or may extinguish his kind forever if unconscious destructive impulses overpower his reason as they have done in the past. If man is to learn how to master his fate rather than to continue as the unwitting victim of his impulses, then the exploration of his unconscious must be one of his major concerns.

What methods are used to explore the unconscious? What is the success of these methods?

The unconscious is not accessible to direct observation. It can be studied only by making its contents conscious (transformation) or by inferring its nature from its manifest effects (interpretation).

The psychoanalytic techniques remain the most prevalent methods for its exploration. In "free association" the patient agrees to express whatever thoughts and feelings come to his mind—without omission or censorship. This produces more and more revealing information about his unconscious life. The free associations enable the analyst to interpret the patient's dreams, his behavior inside and outside therapy, and the unconscious determinants of the person's healthy functioning as well as the effects of his emotional illness.

Historically, hypnosis was the earliest experimental method to demonstrate unconscious phenomena. Freud employed it in his early work, but because of its limitations he abandoned it in favor of free associations. Some scientists still use hypnosis for the study of the unconscious. (See *Hypnosis*)

Sodium Amytal, sometimes referred to as "truth serum," and similar drugs have been used with moderate success in "narcoanalysis" to uncover unconscious material in select cases. Some researchers claim that certain drugs such as mescaline or L.S.D. liberate unconscious material in the form of hallucinations and perceptual or attitudinal changes. (See *Psychopharmacology*)

Some psychological tests such as the Rorschach (inkblot) test and the Thematic Apperception Test (T.A.T.) have proved valuable to check certain assumptions about the unconscious by using an approach different from the clinical. (See *Psychodiagnostic and Personality Testing*)

Freud and many analysts after him have gained important insights into the workings of the unconscious by studying cultural institutions, customs, traditions, religions, myths, and artistic creations. Anthropologists and sociologists have attempted to interpret their findings in the light of psychoanalytic theories on the unconscious and, in turn, they

contributed to its deeper understanding. (See *Social Anthropology and Mental Health; Social Factors in Mental Illness*)

Sophisticated experimental designs of psychologists and observations by ethologists produce data that add to clearer understanding of the human mind.

Finally, recent research in neurophysiology and improved understanding of the structure and the functioning of the central nervous system may in time help us to construct even more useful conceptual models than are at our disposal today.

How is the exploration of the unconscious used in treatment of emotionally disturbed individuals?

The emotionally disturbed individual may be thought of as overwhelmed by impulses originating in the unconscious or as defending himself against them so strongly that he stifles his creative and imaginative resources. In either case—and both may often be true for one and the same person—his emotional life is impoverished and his effectiveness in dealing with the tasks of living is below his best potential.

Treatment aims at establishing better communication between the person's consciousness and his inner life. This should help him to accept himself rather than to fight himself, and to find less frustrating and less destructive solutions for his specific needs.

The exploration of the unconscious is one of several avenues toward such goals.

WAR AND MENTAL HEALTH

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What is war? Cold war?

War is a relation of armed conflict between members of the world political arena. We leave to one side the many distinctions that are made for legal purposes, and focus upon the broad difference between hot and cold war.

Cold war is a conflict between two nations or groups of nations by means of power politics, economic pressures, spy activities, or hostile propaganda, and often sabotage, without actually resorting to arms.

Does war affect mental health?

Yes. However, it is not always easy to trace the connection because war and preparation for war have many subtle effects.

Is war influenced by mental health?

Yes. War is one of the oldest institutions in human history or pre-history; but since war is the result of many factors, it is difficult to estimate the importance of mental disturbance upon these factors.

Are active combatants especially affected?

The impact of warfare upon active combatants depends in part upon the degree to which they accept war in general and the particular war of the moment. A classical case of popular war was the armed expansion of the Islamic Empire throughout the Middle East and North Africa. Warriors were deeply identified with the tribes from which they came and were unified in their zeal for the propagation of a universal faith. They expected an immediate heavenly reward if they died in battle with the infidel.

Does industrialism undermine willingness to fight?

The rise of modern civilization has introduced great changes into the relationship of the individual combatant to warfare, and these

changes are affecting mental health. Traditional religious or "sacred ideologies" have been undermined by the world view of science, technology, and industrialism. New "secular ideologies" depict possible utopias on earth. They appeal to individual ambition and sense of responsibility. At the same time they require individuals to be willing to die now, and this generates mental conflict.

How is mental health affected?

In advanced industrial countries more young people seem to wonder why they should sacrifice their lives for others. Objections are not noticeable when sudden crises like Pearl Harbor sweep young men and women into the armed forces. The undercurrent is more obvious when justification of war is less widely acknowledged, as in the case of Korea. Lack of inner commitment results in mental disturbances and physical troubles influenced by mental factors. In general, a situation of stalemate is more destructive to the mental health of individualistic, ambitious officers and men from advanced industrial nations than from other communities. To a young person reared in an individualistic civilization any threat to "my" life and career is especially disturbing. It arouses deep fear of loss and resentment of sacrifice. Attempts to repress these sentiments are not always successful and contribute to "battle psychoses" among combatants.

What affects the mental health of noncombatants?

The term "noncombatant" has been made almost obsolete by the planes and missiles of modern warfare that carry the risk of death to everyone. Hence, the mental difficulties of soldier or civilian tend to resemble one another more closely. To some extent, however, it is possible to identify distinctive "home front" problems of wives and mothers who are condemned to worry and wait, and who respond to stress with mental illnesses.

Does war have positive effects on mental health?

For many men and women war brings positive gains. Benjamin Rush, an American physician, pointed out years ago that many self-centered people lose their symptoms in the excitement and mutual support of war.

Social scientists and psychiatrists call attention to the sense of isolation that comes to many human beings under the complex conditions

of urban industrial civilization. War, with its insatiable need for manpower, reaches beyond the young and gives to innumerable men and women of middle (or later) years a gratifying conviction of being wanted.

It has also been pointed out that when democratic norms are combined with industrial civilization people are encouraged to make a wide variety of choices relating to every sphere of life. To make decisions is confusing and produces anxiety for many people who, in Erich Fromm's phrase, "escape from freedom." In war, life is simplified for the rank and file who are summoned to serve in great military or civilian structures of administration.

What are the long-run effects of war on mental health?

It is obvious that the consequences of a particular war on mental health are long and drawn-out. Many veterans are never able to recover from mental illness and never return to active life. Some civilians, too, are permanent mental casualties. Combatants and noncombatants alike may not develop serious mental illness until years after the war experience—an experience that played an important part in their eventual breakdown.

More subtle are psychic scars that do not bring hospitalization but disrupt harmonious human relations. Victims of terror relive their experiences for years afterward, often as brief psychotic episodes. Disturbances are especially apparent in intimate affairs. Difficulties of sexual adjustment may be rooted in guilt and shame for illicit heterosexual, homosexual, and other experiences that occurred under the special circumstances of war. Divorce rates jump in the immediate aftermath of war, often reflecting the mental instability of the partners.

During war, parents, especially fathers, are removed from the home, and there are indications that the lack of stable authority contributes to the growth of disturbed and delinquent youth. Wars typically leave in their wake an army of illegitimate children, many of whom are eventually disoriented from lack of affection or from positive contempt. Such problems are exaggerated when race mixture occurs, as in the case of the illegitimate children left by American forces in Japan after World War II and the occupation.

Mental difficulties stemming from war contribute to occupational, as well as to intimate, problems. Immediately after release from the armed forces many individuals are so disturbed that they cannot "settle down" to everyday living or schooling; and they have bad records as

employees. Having once fallen behind his age-mates a veteran often complicates his life by a mounting sense of failure, which he may then seek to resolve by illness.

Are political consequences affected by mental disorder?

We have been enumerating some of the intimate and occupational results of the mental disorders affected by war. The public political consequences of disorientation are equally conspicuous. Every country faces a postwar flood of ex-servicemen; and public order is often endangered by psychopathic individuals who maintained a precarious place in society under the peculiar conditions of war, and who find it intolerable to convert themselves to peacetime activities.

The political impact of the demobilized veteran may be catastrophic in a defeated power. The United States has never faced the trauma of defeat in war; we must not, however, lose sight of the disturbances that followed in the South after 1865. Nor can we overlook the part that was played in anti-foreign, anti-Catholic, anti-Jewish, and related Ku Klux Klan movements immediately after World War I.

We are, however, acquainted with the history of defeat in Germany after World War I, for instance, and the rise of so-called "patriotic associations" and "workers' militias." In the name of communism, socialism, republicanism, monarchism, nationalism—and of many other political philosophies—undeclared wars were fought in the streets of Berlin, in the Rhineland and the Ruhr, in Bavaria, Saxony, and Silesia. Out of the turmoil of the time the Nazi movement eventually rode to success. Many of its early heroes and organizers were men and women of conspicuous mental pathology. Since most of Germany was unoccupied by the victors, these tendencies were more fully and immediately expressed than in some other defeated countries.

Does the prospect of annihilation affect mental health?

It is sometimes suggested that a new factor has entered world politics which is bound to affect the future of war itself, as well as mental stability. This is the prospect of annihilation.

It is probably safe to say that the development of modern weapons of destruction has had some, though so far not great, impacts upon mental health. Psychiatrists know that public topics are typical themes of private worry; however, the origin of the private worry is usually not the public problem.

How do people defend themselves against terror?

The most interesting question about the specter of annihilation is why people appear to be so little affected. A clue is offered by the experience of Western Europe as the year 1000 A.D. approached. For many generations it had been freely prophesied that the world would come to an end, that sinners would be consigned to hell, and the righteous would receive their eternal reward. As the millennium came nearer, social order began to break down in many localities. There was evidence of mental disturbance on a large scale. But observers do not agree that anything of the kind is visible among us now despite the worldwide publicity of the mounting danger to man's survival. Since no definite, irrevocable date is agreed upon, it may possibly be assumed that doom will be deferred indefinitely. From present studies of mental mechanisms we have in recent times become aware of the many means available to the individual for "softening" disagreeable realities. Evidently these studies provide the key to the massive complacency of ourselves and our contemporaries under present conditions.

Is war to be classified as an illness?

The obvious destructiveness of war to life and civilization has prompted the suggestion that physicians should agree to classify war as the principal mental disease that afflicts mankind. Even among those who agree to war's destructiveness there are objections raised to this proposal. It is argued that it is important to distinguish between "an obvious individual disorder" and an "accepted pattern of culture" which, though destructive, is lived up to by persons who by ordinary definitions are not regarded as ill.

Does the study of mental illness suggest antiwar strategies?

Whether we call war an illness or not, it is obvious to most friends of humanity that this ancient institution should be done away with. The analysis and treatment of mental illness provides several valuable clues appropriate to a strategy designed to abolish war. One important emphasis is upon avoiding international crises by anticipating provocative conditions. People tend to think uncritically when they are insulted or discriminated against in any way. Under crisis conditions an individual loses control over his deeper impulses, especially when other people in the environment react the same way. It is of the utmost importance, therefore, to anticipate sources of tension and to adopt policies before crisis thinking distorts the picture.

Can psychiatrists and social scientists be helpful advisers?

The suggestion has been made that political leaders should have at their disposal advisers who remind them of the symptoms of distorted thinking and call attention to possible tactics of control. The point is that diplomats and officers, for example, sometimes become personally involved in negotiation and in making estimates of a situation, and begin to lose sight of reality in their desire to humiliate or weaken the other party. If an expert is placed where he can aid insight and understanding, the chances of war are diminished. Attention can be kept upon common goals and upon provocative factors that have contributed to the current problem.

Can illness among officials be detected and dealt with?

The danger that top officials will distort reality as a result of mental illness is greater than ever in view of the dangers of "push button" war and the spread of atomic know-how among nations. More than one important figure has from time to time succumbed to alcoholism. No satisfactory procedure has been agreed upon to protect the nation and the world from the dangers involved.

Can better personnel selection help?

Almost all social institutions make use of testing, interviewing, and checkup methods designed to identify mental illness or incipient disorders of mind and character. These procedures can be readily installed in military and civil career services. Active political leaders, however, are able to elude such screening. Hence, it is often proposed that they, too, be required to meet basic standards of mental fitness before becoming candidates or office holders.

Can the politics of prevention succeed?

It is essential to recognize that political leaders and those led must be willing to run certain risks and to make sacrifices if the present divided world is to be unified under a law of human dignity. The truly difficult question is whether to accept possible loss of freedom in exchange for greater security against death in war. The candor that mental health requires calls for adequate emphasis upon the full complexity of the decisions at stake.

WIDOWHOOD AND MENTAL HEALTH

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What is the incidence of widowhood in the United States?

The United States Bureau of the Census reports that in 1960 there were nearly eight million widows in the United States, an increase of more than 17 per cent since 1950.

Widows outnumber widowers by nearly four to one. The 1960 census reports 2,219,355 widowers, a decrease of 2.4 per cent from the number of widowers reported in 1950.

The younger a woman is than her husband, the more likely she is to be left a widow. Only if a wife is five years older than her husband are the odds against her becoming a widow. Even among women between thirty-five and forty-four who have been married, 4.5 per cent are widows. And in 1951 one out of nine married women was a widow.

The life expectancy for women is higher than for men all over the world except for parts of India. Alva Myrdal and Viola Klein in their book, *Women's Two Roles*, state: "Women, as they grow older, increasingly outnumber men, the ratio passing two to one at extreme ages. This means that the number of women who survive their husbands is considerable. If we make further allowance for the fact that, as a rule, men are two or more years older than their wives, the unavoidable conclusion is that many women have to face years of widowhood without either a provider or an object for their wholehearted attention."

Why has being called a "widow" become painful to many women even beyond its original meaning?

There is a tendency to regard widows as a separate and peculiar category of women. Many women strongly resent the stereotypes associated with the term. While widows have in common a similar traumatic experience, they are no more alike than other women are.

A widow is a woman whose husband has died. Her reaction to this event will vary according to the kind of person she has always been, the

quality of her marriage, and the resources available to her. Charles Dickens said, "Widders are 'ceptions to every rule." He might just as well have said that people are exceptions to every rule.

Is there any preparation for widowhood?

There is increasing recognition that the woman whose husband has died has a difficult task in facing her loss, her grief, and the necessary reorganization of her life. Still, this emotional upheaval has been studied very little.

Proposals have been made for education to encourage marriages in which the wife is at least five years older than the husband, which might be of help in the distant future. Other recommendations include the extension of research on the major causes of death of men and a more definitive preparation of women for greater self-reliance and independence. The latter suggestion implies that women so prepared will be better equipped to manage independently, which would be of considerable help in the reorganization of a woman's life, but only indirectly, if at all, in dealing with her grief.

What is the nature of a widow's grief? Is it necessarily pathological?

Normal grief after the death of a husband has been described by some psychiatrists as a "situational or traumatic experience." Erich Lindemann of the Harvard University Medical School, who has done pioneer work in this country on bereavement responses, states: "At first glance acute grief would not seem to be a medical or psychiatric disorder in the strict sense of the word but rather a normal reaction to a distressing situation. However, the understanding of reactions to traumatic experiences, whether or not they represent a clear-cut neurosis, is important."

Some experts, on the other hand, have concluded that the loss of a husband is usually a trauma too severe for even the healthiest and most intact woman to sustain without some psychological assistance.

At any rate, there is a difference between mourning and melancholia. Mourning is a normal grief reaction; melancholia is a morbid grief reaction, a distortion of normal grief. Frequent symptoms of melancholia include the delay or postponement of any response to the loss; the adoption of the symptoms of the husband's last illness; adoption of his activities, habits, and patterns; overactivity with the absence of a sense of loss; exaggerated self-recrimination, bitterness, and hostility. Melancholia frequently is accompanied by severe physical symptoms, such as asthma, colitis, or arthritis.

Severe melancholia should be recognized as a psychological illness requiring psychological or psychiatric treatment.

What is the "normal" response of a widow to her husband's death?

There are common elements in the experience of wives when their husbands die. This does not mean that all women share identical reactions to this loss, nor that these reactions will be of the same order or degree of intensity. Much will depend on the specific situation, the nature of the marital relationship, available resources for assistance, and the personality organization of the wife.

The initial response to a husband's death is frequently a kind of numbness or paralysis. The widow is unable to integrate what has happened. This numbness is an expression of the struggle against accepting the finality of the loss. Initially, her insulation is a healthy protection against the deep pain and difficult reality. (See *Death*)

This numbness ultimately wears off; reality and pain seep in; a variety of new feelings may appear. There is often physical pain, a tightness in the throat, a choking, an empty feeling, and insomnia. Common physical manifestations include extreme exhaustion and loss of appetite—widows frequently report that "food tastes like sand."

Accompanying these physical reactions is a range of emotional responses: restlessness, with a need for activity that has no purpose; inconsistency, a feeling of being driven in many directions; irritability with no apparent provocation and an accompanying sense of resignation, as though nothing mattered. Everything appears distorted, out of focus. There is often a relentless preoccupation with the image of the husband and a withdrawal from the usual patterns of living. Impatience with other people is common, despite a dread of being alone; a deep sense of isolation is experienced even among close friends and relatives. The widow may accuse herself of negligence and berate herself for not having been a more devoted wife—expressions of her strong sense of guilt and self-pity. (See *Guilt; Grief*)

What other deep emotions may a widow be expected to feel?

A widow loses not only her husband but also her immediate family, her special status as a wife, and an adult relationship on which she has relied in many ways. Helplessness to combat death, to restore all this, leaves her feeling impotent and fearful as to her capacity to manage. The widow is least prepared for the resentment and anger she feels as a result of her frustration. Widows are expected to be sad and unhappy and they expect this of themselves. Consequently, they feel consterna-

tion and even "disapproval" of the anger and hostility generated by their grief.

This anger is hard to understand and deal with. There is no specific person to blame or apparent acceptable reason for the anger. Women frequently try to deny its existence because they are shocked by such "unacceptable" emotions. They may turn this anger in upon themselves by questioning their own worth, or they may unwittingly divert their anger to friends and relatives, whose offers of solace and help they reject.

Preoccupation with the image of the lost husband often leads to his idealization and a denial of any negative feelings toward him. The reality of the man who has died is blurred. Blame for even minor things that went amiss in the marriage are, as a result, often unrealistically assumed by the widow. She thus may intensify her guilt and her sense of personal inadequacy.

It is often said that time heals all wounds. Should a widow rely on time alone or can she facilitate the healing process?

A widow's grief and mourning are themselves curative if they can be expressed and understood. Death of the husband is a form of separation—a breaking of a close relationship comparable to an amputation.

The widow has experienced deep shock, and she has had to call on reserves of physical and emotional strength to meet the crisis. This leaves her physically and emotionally depleted, but she can help to restore herself. A period of convalescence for the expression and release of pain and the understanding of it, and for the rebuilding of energy, is essential.

She can first try to understand the impact of the shock and the normal reactions to it. If she succeeds, she can then accept the feelings that follow as being natural and necessary, and deal with them rather than bypass them. The pain must be faced and expressed or it remains a wound indefinitely.

The widow next needs to understand that although she can do nothing about what has happened, she does have the capacity to make the necessary changes in her life now that she has become a single person.

Is it harmful for the widow to express her grief freely?

A common illusion is that the expression of grief will cause a breakdown. The reverse is actually true. Strong feelings must be venti-

lated or they may cause severe emotional damage. The poet, William Cowper, summarized this aptly: "Grief is itself a medicine."

Social patterns today tend to inhibit expression of grief. There is pressure on the individual to deny the reality of death and the pain it evokes. The widow is discouraged from expressing her own feelings about her loss, not only in her dress but also in her relationships with others. Deep mourning even for a relatively short time is no longer observed.

How and where does the widow find avenues for expressing her feelings and understanding them?

Sometimes these can be found with friends and relatives. Often, however, they do not know how to help the widow. Close associates, it is said, are at a loss for the right words. With the best of intentions they may offer advice and try to distract the widow from her grief. For the widow herself to understand her own feelings is difficult; it is even harder for friends and relatives. And what the widow feels is that no one can really understand or share her feelings.

An avenue for assistance that merits careful consideration by the widow is that of professional consultation. There are specific advantages in securing trained and experienced psychological aid from a family service agency, a mental health clinic, or privately with a well-trained and experienced pastoral counselor, psychologist, psychiatrist, or social worker. This aid can facilitate the restitutive process for the widow and help her to build her impaired sense of self, and to make the transition to life as a single woman. If such consultation is sought not too long after the husband's death, it may also serve to avert the making of significant decisions hastily and impulsively.

With the death of the husband, the usual anchors for the wife are gone. She is faced with many decisions and various pressures to act. Although the analogy has limited application, a widow can be compared with a man who has had his arm amputated. Both need a period to recover from the shock, and help to learn that they can live, despite their loss, although differently.

Is there a "normal" time during which a woman can expect to recover from her pain and grief?

Time limits for mourning, in the past, have been defined by the culture and were determined by what was considered the period necessary to protect a widow from social pressures, as well as to show

“proper respect” to the husband. The conventional period in which a widow is now expected to recover herself is generally a year, although such generalizations are patently unreliable. The woman who can be helped to recognize that, although something outside herself has altered her life, she is not powerless to make constructive changes for herself, can function with some measure of independence within a few months.

Normally the pain of the mourning process steadily diminishes, although this is rarely recognized by the widow as it is happening. When the process is nearly complete, new experiences begin to claim her attention.

Does a widow have to “start all over again”?

A common error is that the widow should make radical changes in her life quickly. Many think this will obliterate painful memories and, distracted from her grief, she will more quickly “get over” her loss.

Such a course rarely is effective. In many instances it serves to create other emotional disturbances. Unnecessary radical changes may increase the burdens.

Circumstances may require that the widow make immediate and radical changes in her life. If, however, this is not the situation, the widow does better if she can take time to:

- 1) Face and accept the reality of her husband's death.
- 2) Deal with the emotional upheaval that ensues.
- 3) Get perspective as to what in her life must be changed and what choices are open to her.
- 4) Determine what was good in the past and how it can be built on in the present by thinking through her own needs and wishes; her resources and capacities; her choices of those designs in her former life she will want to continue and those she will want to change.

Is it true, as statisticians report, that the majority of widows spend their lump-sum insurance money within a year after receiving it?

There is no single answer to this question. We know that lump-sum insurance money gives many women a larger amount of money at one time than they have ever had before in their lives. But it may also mean that there is no dependable steady source of income. Women accustomed to regular income may find it difficult to plan or manage.

The insurance money comes when a widow is still severely upset. Money, perhaps because it is so basic a reality in life, and also so

symbolic, can all too often become the peg on which to hang our emotional hats, even unknowingly. A widow can more readily and with greater social acceptance express anxiety about how she will manage financially, than she can about her fear of living without her husband by her side. Because of its tangibility, money tends to receive more attention as a problem than do some of the more complex and elusive emotions of grief and loss. For many widows the financial situation forces them to make unwelcome changes. The discomfort inherent in these changes creates conflict.

It is not unusual for the widow who feels deeply deprived to react to financial considerations with intensification of her sense of "having nothing" and "being nothing." These feelings may find expression in seemingly irrational spending or saving. For the widow, the money is sometimes the "only thing I have to hold onto." At other times, by spending it either on herself or on her children, the widow compensates for her loss and deprivation.

Many of the questions and concerns about money are real. The widow may find that what she has, although at first it seemed like a great deal, is inadequate to continue her customary standard of living. Where should she cut? How can she preserve what she has? How shall she give the children what she and her husband had always planned for them?

A widow, initially, may find it hard to determine her financial reality. Again, radical decisions are better made only when she has clarified which changes are necessary and desirable. The widow, in her budgeting, needs to consider not only practical and economic factors, but also the psychological necessities for her social living.

When a husband dies and leaves young children, is it possible to be father and mother to the children?

The only answer is, "No." Many widows try to do the impossible at great cost to themselves and their children.

Nor can the widow "live for her children alone" or "through her children" without damage to each of the family members. Women who try to do this are often misguidedly complimented for it and are looked upon favorably in the community.

No matter how much she would like to, the widow cannot protect her children any more than she can herself from the reality of the loss of a significant family member. But she can give them emotional support and continue to help them grow and develop.

One of the most difficult tasks for the widow with growing children is to achieve the balance of her own needs as a woman and her children's needs from their mother. A desirable balance is especially important for the widow, who has valid needs as a woman in her social life among adults.

Recognition of this need has led to the development in the last few years of an organization called Parents Without Partners, 80 Fifth Avenue, New York City, by divorced and widowed parents seeking understanding of their special needs as single parents, as well as social programs for themselves and their children.

Widows with young children may be told, "You are lucky to be left with children—at least you have something to live for." There is much truth in this, but although children can give a widow a clear purpose in life and a continuity of family living, they also represent a real responsibility to be carried alone.

Should young children be told about their father's death immediately? What should they be told, and who should tell them?

While it may be difficult and painful for the mother to discuss the father's death with the children, if at all possible, she should be the one to do this. It is a fallacy to think that giving way to her feelings will make it difficult for the child. Children need to know that adults care for each other. The mother's expression of feelings for the father and his loss is normal. If the mother cannot tell the children, it could be done by someone close to them, who will be seeing them often enough to answer their questions consistently.

Children, even if not told what has happened, know that something is wrong. While they have a healthy resilience with which to meet trouble, if they do not know what has happened, their capacity for fantasy may lead them grossly to distort notions of what is wrong.

Children have feelings and anxieties about their father's death; usually, they do not know how to express them. Telling them in a simple and factual way of their father's death will enable them to ask questions and to express their feelings.

The child's response to his father's death and the feeling expressed will be on his own level of maturity, which is different from that of an adult. He may act in a way that seems callous—he may even say he's glad his father is dead. This does not mean that the child does not feel deeply about what has happened to him.

Many of the child's indirect expressions and questions will be his way

of seeking assurance that, although his father has died, he will be taken care of. Young children need reassurance that they will not be abandoned. Their primary insecurity may be based on the fact that they do not know what will happen to them now that their father is gone.

A widow who can help her children with their loss may thereby help herself. She can deal with her feelings directly, and begin to restructure the new family group.

Can adolescent children share a mother's grief and understand how she feels?

Although the adolescent child seems old enough to understand and share his mother's feelings about his father's death, he is still a child and cannot comprehend entirely. A wife's loss of her husband is very different from a child's loss of his father. The relationship of each family member evokes a different emotional response to the loss.

Although adolescents may not be able to respond directly to grief and loss, it does not mean that they do not feel—frequently it is the very intensity of their feeling and fear that inhibit their expression. That is why they need encouragement and emotional support to help them articulate some of their fears and pain.

Grown children can share grief with their mother on an adult feeling level. However, the death of the father clearly underlines for the adult son or daughter the change in his or her role as a responsible adult. Grown children, although adults, may now for the first time have to assume responsibilities not only for themselves but also for the mother, on whom they have been dependent for so long. It would help if she tried to understand the changes in their situation and their consequent response to new responsibility.

Is it more difficult for the older widow to adjust to the major changes necessary in her life when her husband dies?

Age alone need not be a barrier for the older woman in making the necessary changes in her life. The older woman, though she may have given little attention to it, has made adaptations in her family role and relationships throughout her marriage and has acquired many skills in the process.

Some of the unique difficulties for the older widow arise from limited resources for employment, if it is necessary. Others may arise

from conflicting values about how an older woman should plan her life when her husband dies. Is it acceptable for her to live alone? Should she live with her adult children? What resources are available to her for companionship and social activities? What are her financial limitations and will these necessitate her dependence on her children?

Can work or activity provide release of pain and solace for the widow?

Work may have concrete and specific value for the widow. It may be necessary for her to work to maintain herself and her family, and in so doing she may rediscover that she can function adequately and that she still has value in her community.

Employment or volunteer work will not, however, take the place of the necessary activity of dealing with pain and grief. When work is used to escape from these feelings, the evasion only delays solutions to the inherent problems and increases their complexity.

Clarification of what she is seeking for herself through work has significant value for the widow. Some widows may, without awareness, use work as a substitute for marriage and the avoidance of return to normal social life.

The widow who has not worked for years finds added problems in employment. She may need to assess her skills, her financial and emotional needs from work, and the resources available to her. For the older widow this is extremely important so that the search for employment does not magnify the feelings of uselessness, inadequacy, and rejection.

Resources for learning about job openings, retraining possibilities, and evaluation of skills in popular demand are now available in many communities. Local offices of the State Employment Service provide, without fee, information on job openings in the area. In large cities, there is a variety of vocational guidance and job retraining services. Sponsorship may be in the local universities, the YW-YMCA or YW-YMHA. Information about such services is usually available through the local welfare council, churches or synagogues, the community chest, local high school guidance program, and some public libraries.

How have the prevailing community attitudes toward widows changed in recent years?

There has been a marked change in the general attitudes toward social conventions for the widow. Some of this change results from the

alteration in the woman's role in marriage and in the world in general; some, from changed attitudes toward death and the expression of sentiment.

Women today are more generally accepted as independent and able to provide for themselves. Marriage is now seen less as an economic arrangement for the wife than a joint emotional relationship for husband and wife. Employment reports for the last decade reveal that there are more married women than single women in the labor force.

Similarly, conventions for the widow have changed. She no longer wears "widow's weeds" nor is identified in any other way. Social patterns no longer regulate the mourning period nor the widow's return to normal social life. The widow is left to determine for herself how she will behave.

Twentieth-century suspicion of emotion and sentiment has made taboo the expression of deep feeling. Absence of a consistent etiquette for dealing with it adds to the widow's problems in her social relationships. No period is set apart in which to integrate her situation. Social life, work, and other responsibilities may continue with little respite for dealing with the new situation. It is no longer taken for granted that the widow needs social protection. The general approach is that it is best for her to face her realities, to prevent her from clinging dependently to others, so that she "can get back to normal."

Are there obstacles for widows in remarriage?

The majority of second marriages of widows takes place between two and four years after the death of the first husband.

Despite powerful and continuing interest in male companionship and sex, many widows do not remarry. As yet there is no clear explanation for this.

There is some reason to believe that one factor is the idealization of the first mate, which becomes a blurred but stabilized image of a person. Comparisons are made between men alive and available for marriage and a fictitious standard attributed to the idealized image of the first husband.

Another possible factor may be fear of further change and adaptation to new relationships. After the widow has invested much of herself in learning to live alone, she may find it difficult to anticipate the new adaptations to be made in marriage, which could explain why most remarriages occur from two to four years after the first husband's death.

What resources in the community are available to the widow if she needs assistance?

Many community services have been developed out of the recognition that when people encounter crises in their lives, it is not always wise for them to struggle through unassisted. We have also learned that it takes strength to seek help when need exists, and that such effort is not weakness. The use of the "right" kind of assistance at the "right" time can conserve our strengths and make them available for healthy living. Nevertheless, fear of loss of independence or of being thought weak and helpless may all too often deter the widow from using available resources for herself and her family.

In most communities, family service agencies, including religious organizations for those who belong to them, provide assistance to individuals with family problems. They are also often a source of information on private professional practitioners or other kinds of community services. Similar service is available through local mental health clinics. These may be located through the local welfare or health council or the state mental health department or society.

Financial assistance, when necessary, may be available through the local family agency for short periods of time, or through the local department of welfare or public assistance.

It is also of help to check carefully with the local Social Security district office as to a widow's eligibility for Social Security benefits.

The widow may not have to make major changes in her social relationships. However, it usually becomes necessary to find new avenues of interest, new social experience, and leisure-time activity. The latter are often part of church or synagogue programs, local community centers, and the YW-YMCA and YW-YMHA services. The public library, museums, and university centers may offer a variety of courses, clubs, and other types of activities.

Do all widows need the help provided by these services to manage?

One can no more generalize about widows than one can about other people. The major task for the widow is to recognize that the capacity to change is an inherent human resource, although a variable one, and then determine the areas in her own life in which change is necessary for her to make a life for herself as a single woman or a single parent. Many widows, on their own initiative, have found within themselves capacities and strengths that have helped them to grow and develop, to find avenues of creative expression through work,

volunteer services, social activity, or the many activities associated with their children's lives.

Is it true that the widower has an easier time than the widow in making adaptation to his loss?

Although it is commonly assumed that widowers adapt themselves more readily to their loss than widows, there is no evidence to support this assumption.

There are practically no data available on the widower and his adjustment to the death of his wife. It can, however, be assumed from studies in bereavement that the widower has similar problems in dealing with his feelings of grief and loss. We do know that widowers represent a much smaller segment of the population than do widows, and that they tend to remarry much sooner.

Why is it assumed that widowers have fewer problems than widows?

Some reasons are:

For the woman, marriage and the home is said to take priority as a goal and as a way of life. For the man, it is assumed that his work or career is his first priority; that his family and his home come second.

Consequently, based on these assumptions, when her marriage has dissolved and her home is no longer intact, the widow's loss is a major and severe one. It involves a loss of a significant relationship, loss of purpose, status, and of position.

Similarly, under these assumptions, the man continues his primary role in life unchanged when his wife dies. All he experiences is a loss in an intimate living relationship.

Actually the problems the widower has will depend, as they do for the widow, on the kind of person he is and on his situation. Perhaps a most significant difference appears in the widower's opportunity to deal with the grief he feels and with his emotional response to his loss.

In our culture, it is assumed that "men must be strong and women may weep in the face of adversity." It is also taken for granted that a man cannot afford to take too much time for grief; it is necessary for him to carry on the task of making a living.

The etiquette for mourning for the widower has always been more flexible than that for the widow.

Consequently, for the man who has lost his wife by death, the conventions make it difficult for him to deal with his grief, to express his pain and sense of loss. It is a current generalization that the male in

Western culture is less emotional and given to sentiment than the female. Whether this is a fact we do not know. We do know that this is the pattern set by the culture. A man in our society is expected to be the master of his feelings—only “sissies cry.”

It is also assumed that men, although the pursuers and the wooers, are led into marriage or even “trapped” into it by women, for whom the institution of marriage is so essential. So far as we know, the male’s need for a relationship in which he belongs, receives love, and can give love, is as vital and necessary for him as it is for the female. Consequently, when he has had a marriage with a wife who has fulfilled these needs, his loss, and pain in his loss, has the same depth and deprivation as a wife’s loss of her husband.

When there are young or growing children, the widower, depending on his economic and social circumstances, like the widow, faces many problems in providing care for these children as a single parent. It has often been said that the growing child who loses his mother has greater deprivation than when the father dies.

The mother is still accepted as the nurturer of the child despite the increased emphasis today on the father’s relationship with his children. This puts considerable pressure on the widower to provide in some way for a mothering person to care for his children.

The widower has other pressures on him. Unlike the widow, his “extra” status makes him a social asset. He is usually, as a result, in great social demand. Some widowers resent the many social pressures and efforts that are made to involve them quickly in social relationships with “eligible” women.

It is unfortunate that, because of the many assumptions rather loosely reached, the widower’s adaptation problems have had no serious study or consideration. The meaningful relationship with a mate, a pattern of belonging and needing to belong as part of a family group, seems as necessary for the man as for the woman in our kind of world. Otherwise, despite the pressures, widowers would not remarry so readily.

WORK AND MENTAL HEALTH

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How important is an individual's job in relation to his mental health?

In Western industrialized society, a man's job is not only a means of earning a living but it is also a way of establishing himself as an adult. Many of our surnames—Carpenter, Weaver, Taylor, etc.—are derived from work roles. In evolving his basic social role through his work, a man also has some way of judging his own adequacy, worth, and contribution as an adult. The idea of establishing oneself early in an occupational role is so important that we give heavy emphasis to vocational guidance in secondary schools, and we even go so far as to ask many preschool children what they are going to be when they grow up.

Speaking psychologically, hiring and firing on a job is tantamount to the early childhood experiences of being given or being denied love and affection. When a person is employed, he is told in effect that he is desired and that he is looked upon as worthy of working with others. When he is discharged, he is told he is no longer wanted. The importance to the mental health of a person of being wanted and needed has long been recognized.

In addition to the importance of a man's job for his identity as an adult and for the experience of being needed, work is important to mental health simply because so much of one's life is devoted to it. Man spends more than a third of his waking hours at his work (often many more) over the course of a working lifetime. His work frequently antedates his marriage and usually continues long after his children have become adults. Within this time span, a person establishes relationships with other people, from which he derives status, prestige, affection, social membership, support in personal emergencies, and so on. He takes part in a social system. He is subject to many different kinds of pressures from both his colleagues and his superiors. If he is in a supervisory role he is also subject to certain pressures from those whom he supervises.

A human being spends many years growing up. As a child and later

as an adolescent he is dependent on adults. He becomes interdependent when he grows up. That is, he is able to obtain satisfaction by depending on others, provided that he, in turn, is able to let others depend on him. In a work situation, the company or those for whom he renders services depend on the person. He depends on his superiors for guidance, direction, job security and so on, and they in turn depend on him for his part of the job.

A job is an avenue for evolving comfortable relationships with other people. Some people prefer to work very closely with others and can seek jobs which provide that closeness. Others, to be comfortable, seek out more isolated jobs. Sometimes a man is forced into situations in which the distance is not comfortable for him. This balanced distance from other people has a counterpart in balanced distance from other aspects of life. In going to work, many people are able to separate themselves temporarily from personal and family problems. And when they return from their work, having put these problems aside for the day, they are more psychologically refreshed and better able to cope with their personal problems. This is particularly true of many women who go to work primarily for respite from home and family pressures.

An important consideration is a person's relationship to the organization in which he works. A business organization and the social structure surrounding it have increasingly come to take the supportive place of the fast-disappearing small community. When ours was primarily an agricultural society, people depended on their neighbors for help in emergencies, and their roles in their communities were their avenues for achieving adult identity. Now a business organization often meets these needs for many people, particularly for those in larger organizations in metropolitan areas. This is particularly evident in fringe benefits, especially in post-retirement interest in and help for the retired employee, and in the identification of the person not alone as "Joe Jones" but usually as "Joe Jones, foreman at Apex Electric."

The importance of work to mental health is reflected in the relationship of symptoms of mental illness to various aspects of work. Arthur Kornhauser of Wayne University reports that the fewer a man's occupational skills, the more symptoms he says he has. John R. P. French of the University of Michigan reports European studies indicate a greater incidence of ulcers among supervisors than among line people, reflecting supervisors' difficulty in having other people depend upon them. It is not unusual for psychiatrists and psychologists in business and industry to find people demonstrating symptoms because they have been

given job responsibilities beyond those they think they are capable of carrying. In some business organizations, not to be promoted regularly is taken to be a sign of failure. By this kind of an artificial standard, many people judge themselves to be inadequate.

The psychological importance of the business organization to the individual is seen most poignantly in the many problems of retirement. Most people find it difficult to retire and some go to great lengths to deny that they will have to retire. "The job has been my life," many will say. And they experience compulsory retirement as rejection.

There is considerable evidence that accidents, absenteeism, turnover, frequent visits to the medical department, and frequent requests for transfer are some ways to escape work situations which create too much tension for the individual. Apathy, withdrawal, passive resistance, and open conflict at work are often reflections of the employee's feeling of uselessness and futility, particularly when he can use only a small proportion of his skills and abilities.

A recent Michigan supreme court decision has held that working conditions can precipitate psychosis or severe mental illness. Prior to that decision, there was a long history of industrial responsibility for traumatic neurosis, e.g., if the person had crippling emotional reaction to an accident or shock, his employer could be held responsible if the shock or accident occurred on the job. The Michigan decision, however, was not concerned with shock or accident but with stresses created by the job.

A man's work is a major outlet for his instinctual energies, for his creativity. It is for these reasons that work is so important as a therapy in mental hospitals. Sigmund Freud said that he hoped his patients would be able to do two things: work and love. Work, then, is one of the cornerstones of mental health.

What specific factors in the work situation help make for greater satisfaction?

According to an important study, *The Motivation to Work*, by F. Herzberg, B. Mausner, and B. Snyderman, achievement, recognition, the work itself, responsibility, and advancement are the factors most closely related to increasing job satisfaction. These "satisfiers" relate to the actual job. Company policies and administration, supervision, and working conditions are the major factors which cause job dissatisfaction. Salary, they say, has more potency as a job dissatisfier than as a job satisfier.

What factors in the work situation lead to the best working conditions and productivity?

In general those which recognize the employee as a responsible adult. In our society, when a person is twenty-one he is credited with having sufficient intelligence to help elect the president and the Congress and in that way to contribute to the policies of the government. In business and industry, however, rarely is he asked to share in a responsible way in decisions relating to his work. The widespread use of suggestion boxes indicates how little face-to-face conversation goes on in business organizations about the job itself. Studies in the Harwood Company and others indicate that there are significant increases in productivity and decreases in the expression of various forms of hostility when people have a responsible share in planning the work they are going to do. Participation indicates also that management cares sufficiently about employees to listen to them and to permit them to express their feelings. The effectiveness of participation in decision making presumes that there is a satisfactory wage system.

Studies from the Survey Research Center at the University of Michigan indicate that productivity relates significantly to the kind of leadership which people have, particularly leadership which is sensitive to human relations. Productivity is also related to incentive plans that permit the employee groups to set their own production targets and to be rewarded for increased productive efficiency.

Some people, of course, are motivated primarily by money. Others want to fulfill certain ideals. These motives will vary among people and also in the extent to which they may be effective in different businesses and industries. One public utility, for example, after a major hurricane disrupted its facilities, found that there were no accidents in six weeks of emergency work under high pressure and dangerous conditions. These men were so motivated by the feeling that the community was depending upon them to restore service that they rendered almost superhuman service.

How does an individual's feelings about his work affect his feelings about his family? His home? His future?

There is a frequently told story in mental hygiene lectures about a man who was criticized by his boss, who in turn had an argument with his wife. She spanked the child, the child kicked the dog, then the dog chased the cat. This illustrates the displacement of feelings from a

situation in which they cannot be expressed to another situation in which they can be. One's feelings about one's work are frequently displaced onto the home situation. Anger and frustration on the job may well result in hostility or irritability at home.

On the other hand, people who take pride in their work and whose occupational identity is important to them quite often extend that pride to include the appearance of their homes. A man will say, for example, that he must keep his lawn neat and his house painted because people identify him with his company. His pride in his company enhances his pride in himself, his family, and his home.

At the same time, the positive feelings about his work usually are correlated with a positive, optimistic outlook on life. A person can be comfortable about the future because he trusts the future.

Some people single-mindedly devote themselves to their work and to their current interest, whether it be family, home, community, or something else. Such single-minded dedication to work often means that something else must be sacrificed, usually the family.

When work experience holds no promise of further growth or achievement, a man will invest the major part of his energies elsewhere. This often happens at middle age when some men recognize they will remain essentially in the same relative positions for the rest of their working lives. If their salaries are adequate to meet their needs and they can earn their salaries by meeting the minimum requirements of the job, they will do only that which is required of them. Executives refer jokingly to the "male menopause" and complain of the loss of initiative on the part of their subordinates. A subsequent greater investment in home and family will often be to the advantage of both the man and his family, provided the man does not go to work with a feeling of inadequacy or of failure.

The reverse situation is usually more evident because a person is observed more widely in his work than he is at home. It is commonly accepted that personal and family difficulties have such serious effects on work that some companies have provided psychiatric and counseling facilities, as well as special programs for such problems as alcoholism.

What are the methods used to determine the job for which an individual is best suited?

For unskilled or semiskilled jobs where large numbers of people are to be employed, objective psychological tests are widely used to

complement individual interviews. As the job increases in complexity and as criteria for job success are more difficult to define, objective psychological tests become less useful. For executive positions, individual personality tests whose interpretation depends upon the skill of the clinical psychologist are now being more widely used in business and industry.

The best predictor of future job success is a man's previous experience. A detailed description of a man's work experience, when compared with a comprehensive description of the job to be done, is a good starting point for making predictions. When quite an increase in responsibility is involved, particularly at executive levels, it is important to have a comprehensive evaluation of the man's personality. This should include an estimate of the person's skills and capacities, including his intelligence; a description of his personality makeup and the degree to which it relates to the requirements of the job; an estimate of his level of aspiration and how intensively he wants to pursue it through company and professional hierarchies.

Are executives more susceptible to ulcers than employees? If so, why?

There is a popular fallacy that all people who work under considerable tension have a greater tendency to have ulcers than do others. Ulcers apparently result from a particular kind of stress: difficulty in accepting one's own needs to be dependent upon other people. This kind of stress can be increased for some people when they are made responsible for the work of others. They apparently have enough difficulty maintaining their own independence as it is without having the responsibility of supervising others. Such stress may result when one assumes the responsibilities of marriage or parenthood as well as when assuming supervision and leadership. Ulcers are not primarily a work disorder. Whether they do in fact occur more frequently among executives than among employees is still an open question. There is some evidence to indicate that they do, as noted in response to the first question. The evidence is still fragmentary and some of it contradictory.

Men who are trying to demonstrate their independence are likely to seek executive positions, and it seems logical that executives, therefore, should have greater susceptibility. Men have ulcers three times more frequently than women, perhaps a reflection of the fact that men carry the responsibility for families in our society more frequently than do women.

What are the most frequent problems encountered in the employer-employee relationship?

There are several ways of looking at "most frequent" problems. From the writer's point of view there are three general problems which are the same for small and large companies.

The first is the difference in perception between the expectations of the employee and those of the company. The writer's own experience indicates that the company is little aware of the expectations with which people come to it and assumes that people merely want a job. Studies indicate that there is often considerable disparity between what a man thinks he is to do on his job and what his superiors expect him to do. These great differences in perceptions and expectations result in built-in conflict and frustration.

A second major problem is the implicit assumption on the part of management, and usually on the part of union leadership as well, that man is a rational and machinelike animal, motivated solely by money. Despite considerable research and much lip service to the idea that man does not live by bread alone, most incentive programs and efforts to motivate people in the plant are based on individual monetary rewards. Furthermore, most businesses are organized in such a way as to ensure a maximum of control over the individual on the assumption that he cannot be otherwise motivated or guided. As Douglas McGregor of the Massachusetts Institute of Technology pointed out, these concepts of management are psychologically obsolete and result in irresponsibility, apathy, and hostility.

A further important problem, and one that is gaining in importance, is the feeling expressed in the phrase, "I don't know where I stand." This usually does not mean the person does not know how his superiors judge his work, but rather that personal contact with superiors is so limited that he feels nobody really cares about him. The fact that a man is useful to his organization for only very limited skills does not make him feel useful as an individual human being. While no organization can use all the skills and talents available to it, very few people use more than a small fraction of their capacities in their work. Furthermore, many people live uncomfortably with the knowledge that they can readily be replaced by machines.

What effect has the influx of women into executive positions had on industry? What are the attitudes of men in higher positions toward these women?

There has been no influx of women into executive positions in business and industry. The influx has been at lower level positions.

Male executives simply do not think of women as executives. The higher levels of business and industry are essentially a man's world. However, there seems to be a tendency in government and in the southwestern part of the United States for women to advance more readily to executive positions.

Male subordinates respond better to women superiors than do female subordinates. In general, women would rather have men as supervisors. Women complain that women supervisors tend to act more like men when they become supervisors. Such a denial of one's sexual role makes it difficult for both men and women to relate to the woman executive. As a rule, women have been closer than men to their own mothers in the course of growing up and have been more subject to control and direction from them as well as having experienced some degree of rivalry with them for the father's affection. The woman supervisor or executive may be seen in many unconscious ways like a mother. As a rule, boys are less controlled by their mothers and more by their fathers. They are rivals with the father for the mother's attention. Men are less likely to be antagonistic to a woman supervisor unless the nature of the job is such that to have a woman supervisor means that the occupational role is no longer a masculine one.

Some women who seek executive positions are frustrated with their role as women and would prefer to be men. They tend to carry chips on their shoulders as if they were daring the male world to do something which they could not do or do it better than they can. In trying to "out male" the men, they succeed in alienating everyone around them and depriving themselves of the very opportunity they are trying to obtain, thus creating hostile environments for themselves. Some women want to be treated like women, but at the same time they want the privileges of men. They resent being treated by men as equals. Some women, indeed, have all the responsibilities of men in similar positions but get neither the recognition for carrying such responsibilities nor the authority to carry them efficiently. The experience of a woman executive will vary widely in the manner with which she comports herself, the skills and experience which she brings to her job, and with the meaning of that particular work to the people who do it. If she has difficulty with her feminine role, then the difficulty is likely to carry over into the job situation. If she can accept herself fully as a woman, then she seems to have less difficulty.

In several companies women without formal administrative titles act as counselors or "mothers" in the organization. Despite the fact

that these women are in staff positions, they are held in high esteem by the people at all levels and perform an invaluable psychological function for people who turn to them for help with a wide variety of management and personal problems.

Are women given equality on jobs? If not, what problems might this create?

By and large, women do not have equality on jobs either in pay or authority. In part, the reasons are historic. Until recent years, women were thought not to have the same skills as men and they were usually less well educated. In addition, women were unable to commit themselves as fully to their work as men because often they had home obligations. Most women still have to take time from work to have and rear their children. As a result they tend to have less experience than men of the same age. Some of the psychological reasons for the difference were discussed in the answer to the previous question. Often, however, there is no good reason.

For some, these experiences are galling, resulting in chronic resentment. Others recognize their limitations because of the increased demands from growing families. Even women physicians and others in professional circles have the same problems. For certain periods in their careers they must give up or limit their professional activities in the interest of their families. Unless the woman feels she is being treated unfairly, or is unable to fulfill her potentialities, and thus has a continuing feeling of inadequacy, there are not likely to be mental health complications. However, since no one fulfills himself completely in his job and each must establish a range of sources of gratification, there are many possible ways of developing compensations.

How has the concern of corporation management for the personal lives of its executives affected the executive? His family? His friends? His community?

Some people resent the company interest in their personal lives, which they regard as unwarranted intrusion into their privacy. Others recognize that in high executive positions it is difficult to separate personal life from business life. In many instances, for all practical purposes, husbands and wives are employed as a team. Wives are expected to play social roles in their communities in helping with their husbands' positions. They are expected to entertain customers' or clients' wives, and so on. This, however, is an old story among execu-

tives and professional groups, particularly among ministers, most of whom are employed as husband-and-wife teams. It is, therefore, inevitable that corporations should be concerned about the personal lives of their executives.

One major area of concern has been selection and evaluation, particularly for overseas posts. The cost of executive failure overseas is so high and so frequently due to the inability of the executive's wife to adjust to the new culture that corporations and the government have undertaken to evaluate both husband and wife. Such an evaluation is, in fact, in the interest of both employer and employee. The man himself does not want to fail, nor does he want to create inordinate stress for his family. When husbands and wives are apprised of the situations they are going to face and helped to confront their psychological problems in the context of these situations, they usually are grateful for the help that is given them, even when that help results in a decision not to take the assignment.

Corporate concern with the personal lives of executives is destructive if it is paternalistic, i.e., if the corporation treats its executive and his family as if they were children. This generates resentment. In many cases, however, such concern is an honest and genuine effort to help the executive and his family, particularly with the stresses and demands of the executive's work. Many programs for dealing with alcoholism, retirement, moving the family from place to place, and overseas assignments are good examples.

In some cases, the corporation is not concerned enough with the problems of personal life, and particularly with the corporation's impact on personal life, as a result of which the executive often spends far too much of his time away from his family. The company often demands that the executive not only devote extended hours to the company's business but also that he undertake considerable community participation. Many wives and children are chronically angry, sometimes not consciously, at being deserted in this way, although communities have often benefited.

What place does the psychiatrist have in industry? How many companies employ psychiatrists or mental health personnel?

According to the Committee on Psychiatry in Industry of The Group for the Advancement of Psychiatry, the psychiatrist in industry should diagnose and prescribe emergency treatment for mental illness. He should educate labor and management and professional colleagues

about the principles of mental health, particularly as they apply to the work situation. Finally, he should consult with management about policies and practices which affect mental health. No one kind of industry needs mental health personnel more than another, but psychiatrists in industry are found more frequently in those companies with comprehensive medical departments. There the psychiatrist is one of the number of specialists required to have a well-rounded department.

It is hard to say what has been accomplished in industries employing psychiatrists. Many industries have come to appreciate the value of recognizing emotional problems on the job. The high cost of such symptoms as accidents, absenteeism, alcoholism, make it imperative that something be done about emotional problems. Perhaps a half dozen companies employ psychiatrists as formal members of the payroll. The Committee on Industrial Psychiatry of the American Psychiatric Association reports from a survey that some 200 psychiatrists give partial time to business and industry. Most of this is the examination of people who are referred for diagnosis or treatment. Similarly, in other countries, only a few psychiatrists are concerned with industrial problems.

There is only one formal (Cornell University) training program in which psychiatrists may prepare themselves for work in industry. This program, limited to two or three men in any one year, provides a psychiatrist with additional training in personnel work, sociology and psychology, management and labor problems, and so on.

There is no way of knowing how many physicians, psychologists, social workers, and professional personnel, other than psychiatrists, are doing mental health work in industry. Although many psychologists work in industry, only a handful of these are concerned with mental health. There are a number of management consulting firms made up of clinical psychologists who spend much of their time in executive counseling. A few social workers are employed in industry as counselors. Many others who have no formal training are doing personnel counseling.

What qualities are most often prescribed for a good executive?

Despite many studies, there is no common agreement on the qualities of leadership. What makes a good leader seems to vary with the kind of group to be led, the task of the group, and the conditions under which it operates. From the writer's point of view, a good execu-

tive is a guide, a director, a counselor, and a protector. He must be able to permit his subordinates to be dependent on him but at the same time to depend on them. He must give them consistent support and respect to foster psychological growth and the assumption of adult responsibilities. He must also keep a constant focus on the task to be done and create a structure within which people can do it. Psychologically, a good leader is much like a good father.

What has brought about the need for numerous company benefits?

The corporation has come to have considerable economic, social, and political powers. What it does has great impact on the lives of people. Whenever a society permits a person or institution to acquire power over people, those subordinate to that power expect it to be used in their interest. When the power has to do with financial security, then the institution is expected to provide that security. Furthermore, when people have contributed to production they naturally want a fair share of the rewards.

Management has fostered these expectations by trying to promote the identification of the employee with the organization. Many organizations have encouraged employees to remain with them for long periods of time, by accepting the seniority principle and by emphasizing the principle of promotion from within. These circumstances have made employees and executives feel that they have an important share in a business organization and it must therefore serve their needs for job security.

Since many college students seem to prefer employment in large companies rather than in small ones or even to beginning their own new ventures, what are the reasons for this?

Contrary to common belief, comparatively few people have achieved great success in their own businesses. Most manage to struggle along and many, of course, have failed. Not only has it become increasingly difficult because of the capital required for people to start their own businesses, but large companies, in college recruiting, attract men by the promise of great opportunities—greater than they might achieve for themselves—and of job security. The post-World War II decline of small business and the increase of mergers have made it apparent to everyone that small business must face an ever more difficult future. While these trends have been deplored in many circles, there is no clear-cut evidence that people have been affected negatively or that

productivity or creativity, or even the national interest, have been adversely affected.

Only a few people in any age have been truly creative, and only a relative few have attained financial independence. Despite its social problems, our society has had no dearth of respected scientific theories, inventions and discoveries, good literature, etc. It has reached increasingly higher levels of productivity, and provided the highest standard of living ever known.

What, today, are the conditions of employment desired most by people looking for jobs? Are these different from twenty years ago? If so, why?

Job security was the single most important consideration for most people who were looking for jobs twenty years ago, and it still remains so. The feeling of helplessness without job security produces anxiety and this, in turn, precipitates various symptoms. To be without a job, for most people, is to feel helpless. Once job security has been obtained, other things take on importance as motivators, as Abraham Maslow of Brandeis University has demonstrated with his conception of the hierarchy of needs. These other considerations—status, prestige, consideration by management, and opportunities for advancement—will vary from industry to industry and according to the experience and educational level of the people who are involved.

Judgments about the most desired conditions of employment should always be tempered. It is a psychological commonplace that people will displace their feelings onto other subjects when they are either unaware of or cannot express their feelings about specific conditions which dissatisfy them. This circumstance is rarely taken into consideration in studies of work satisfaction. Furthermore, we are always dealing with the interrelationships of a complex of factors, and these must be understood as they operate together.

How has automation affected mental health?

Automation has made it possible for many people to acquire semi-skilled and skilled jobs who otherwise would have had unskilled jobs, and it has lifted much of the burden of menial chores from human beings. In the sense that it has enabled people to use more of their capacities, it has contributed to mental health.

The introduction of automation, however, has had some deleterious effects in that some people have not been adequately prepared for the

change to automation, and others have lost occupational status as new methods have made old skills obsolete. These people have suffered psychological loss. They have found it difficult to adapt, to learn new skills, and to assume new responsibilities. In some organizations the network of social relationships which had been established was disrupted by the introduction of automation.

What might be the effect of more automation on mental health in the future?

Automation will require higher levels of education and thus bring an increased interest in, and appreciation of, a wider variety of experiences. Given freedom from oppressive mechanical chores and greater intellectual resources, this will hopefully make it possible for people to have more time to give to their families and to spontaneous creativity in their leisure time. It should also increase the opportunities for people to use their ideas and imagination rather than their muscles in their work. If automation can be introduced in ways which make it possible for people to adapt to it successfully, then it need not, in the writer's judgment, be a threat to mental health.

How have new industries or relocation of industries affected the mental health of the individual?

During the depression of the 1930's there were a number of studies on the impact of unemployment on people. These indicated that the morale of the unemployed was closely related to the amount of time they were unemployed. They tended to lose respect for themselves and even took on women's jobs in the home in order to have something to do. Today in those communities where there are women's jobs available but few jobs for men, there are frequent reports about men's loss of influence as authority figures in the family and, in turn, loss of respect for themselves.

Even the threat of the loss of a job produces fear and shock which spreads through all aspects of a man's life, changing his outlook. It is an accepted psychological fact that as levels of success decline, levels of aspiration tend to decline as well, and thus people can lose much of their motivation to achieve.

Having exhausted the resources available to them, many do not know what other ways to turn. If they are unable to leave the areas in which they live because their skills have limited usefulness and they do not know how else they might be usefully employed, or if they do not know

where to go to make themselves useful, or if they do not have the money to move, people tend to become demoralized and to cling to relief rolls. Younger and better educated people with fewer family responsibilities, of course, have more flexibility for movement than do others.

Has the assembly line technique created emotional problems for certain employees? On what does this depend? What can be done for the individual thus affected?

Much has been written about the depersonalizing effects of the assembly line, of requiring people to work at a mechanical rhythm rather than a natural rhythm, of loss of any sense of creativity, etc. Undoubtedly many people feel themselves to be constricted and oppressed by the assembly line process. Some others feel, however, that the assembly line permits them to operate in a mechanical fashion without making many demands upon them and that they are then free to indulge in reverie or to make their jobs secondary to the social relationships and extra-work activities. Some companies have tried to counteract the negative effects of the assembly line by introducing job enlargement programs in which, instead of doing one small part of a task, a person assembles a complete unit. Whether the assembly line creates problems depends on the intelligence and personality of the individual. It depends also on the broader work context and the psychological support which can be drawn from it in terms of the satisfactions described in response to our first four questions. If a person suffers an emotional disturbance precipitated by any kind of job pressure, he will probably require examination. It can then be determined if he should be assigned to another job or if he will require treatment.

Has the large corporation been responsible for creating the conforming man? Are there specific problems which have grown out of the large corporation regarding an individual's concept of himself?

In various ways, from time immemorial, man has been conforming to the demands of his fellows in order to survive among them. To some extent he must conform to remain in any community or work situation. The corporation has not created the conforming man. It may have helped to increase his numbers. Just as it is true that certain kinds of people are attracted to certain communities, so people are attracted to given companies. For example, people who value job security above rapid promotion will tend to choose banks or public utilities, and these

institutions, in turn, because they deal in public services, will seek to employ people who can get along well with the public. Thus, in a vague, general way, businesses tend to develop corporate personality types.

In any hierarchical structure, people move up because they gain the approval of their superiors. They are then less likely to offend their superiors and to that extent they conform to superiors' wishes and expectations. Many people are quite comfortable with such arrangements because the controls imposed by the organization enhance their personal controls, because the structure of the organization makes their occupational paths evident to them, and because in many ways the organization meets their psychological needs. In some cases they risk loss of their own purposes and goals for those of their superiors, and subsequent discontent with themselves. Many people who wish to do so cannot leave large corporations because they would lose their vested rights in pension and other benefit funds. These people often remain, frequently angry and apathetic. A number of recent novels about the business world have been written by men who left it in anger and then attacked it, primarily because the individual felt that he demeaned himself when he conformed to the demands and expectations of the business world which were foreign to his own desires. Some argue that the large corporations have been responsible for fostering the dependency of the person rather than enhancing independence. Chris Argyris of Yale, for example, thinks that ways have to be found for undoing dependency, while Robert McMurry believes that most people in corporate hierarchies are dependent people and that they should simply be accepted as such.

How have unions affected the mental health of the employee? The employer?

Marc Karson has argued that the unions have contributed to the mental health of the employees by giving them constructive outlets for their hostilities. Furthermore, by caring about the employee and for him, particularly during periods when management apparently does not, the union gives the employee a sense of power, importance, and status. By its concern for his job security, the elimination of occupational hazards, and the retention of job rights, the union gives the employee considerable ease of mind. Unions have often contributed to the mental health of their employees (and to that of executives) by

making it possible for problems to be brought out in the open and resolved at the bargaining table to the benefit of both parties rather than result in chronic hostility, passive resistance, and outright destruction. Some unions have provided hospital and outpatient care for their members, including psychiatric treatment.

What is work therapy? How successful has it been in treating emotionally disturbed individuals?

Work therapy is the assignment by a therapist of a mental patient to a job in keeping with his psychological needs for the purpose of hastening his recovery. There are no statistics on its usefulness. Since any kind of work a patient does is called work therapy by some hospitals, any statistics would be useless. Experience has shown, however, that when people are able to work they recover from mental illness more quickly. Furthermore, they more readily regain their self-respect and the feeling of being useful members of society.

Does an individual have a basic need to work or is this a product of his culture?

Work is a cultural by-product. Every person needs to have ways in which to discharge his instinctual energies, particularly aggressive energy, but this need not necessarily be in the form of work.

Is an individual's job an indication of his personality and values?

Generally speaking, yes. As long as people seek to fulfill themselves in their work, as long as they use their work as a major way of establishing comfortable relationships with others and to evolve their own identities, where, how, with whom, and under what conditions a person works tells much about his personality and his values.

Can a job change an individual's personality and values? Can generalizations be made about the "Madison Avenue" type in the advertising business, the "Eccentric Egghead" in the education field, etc.?

A job will not change an individual's basic personality structure. It may suppress or elicit some aspects of his personality. He will retain those values about which he feels most strongly. He may change those values which are not strongly held, simply because of the demands of the social role. He may assume others superficially if they are not basically his, but this usually produces conflict. Many people behave as they

think they are expected to, despite their feelings of guilt and uneasiness.

Generalizations can be made about types in the way in which the writer has made them in response to the question on unions. People choose organizations and certain kinds of work, and organizations choose people who fit their needs. General types, with many exceptions which can cover a wide range of personalities, can be identified.

Is an employer a symbolic father to his employees? If so, how does this determine an individual's attitude toward his job, his productivity, etc.?

We all develop attitudes in the course of growing up toward ways of coping with, and expectations of, people who have power over us, particularly toward fathers because they are usually the more powerful parents. As a result, employees have many expectations of the boss which, psychologically, are much like the expectations a child has of his father. Many studies on what makes a good boss confirm the fact that there are generalized expectations about the behavior of the boss that are part of our culture. If the boss does not fulfill these expectations, the subordinates feel they cannot depend upon him. Productivity, conflict, and the appearance of psychological symptoms in individuals and groups are closely linked with the behavior of the boss. Often the behavior of a boss is a reflection of the behavior of his own boss toward him. For that reason it is important that human relations efforts begin with the heads of businesses.

Does an organization whose management holds itself aloof from employees have better productivity and morale than one that stresses familiarity between management and employees?

The question is not one of aloofness or familiarity but rather one of balanced distance. There are times when the individual employee will need help and support from the organization and, at those times, management can be closer. At other times, when a man is doing his work and prefers to do it himself, management or supervision more wisely remains somewhat aloof. Many factors govern how close or how distant management should be from employees. In general, the employee needs to feel he has some degree of freedom to do his job (privacy), some affection from superiors and colleagues, and both organizational and personal control over what he does. Extremes of any of these factors make it difficult to maintain a balanced distance.

Based on current research, what might be predicted about the problem of work in relation to mental health?

There is a growing number of studies on work and mental health. We can expect to see a heavy emphasis on finding out how the organization and operation of a business affect mental health. Any important efforts among adults to prevent mental illness or to foster mental health will necessarily include the workplace. Mental health will become as important a consideration and responsibility to business as is physical health.

Are there special problems of mental health for persons working for federal or local government? For professionals and for independent workers?

Evidence about the special mental health problems of government workers and independent workers is limited and scattered. In the writer's contact with government workers, six general problem areas have been mentioned most frequently. First, those people in government who are involved in the planning and execution of programs frequently report frustration because of the multiple political and administrative forces which impede and delay action. Some become cynical, others lose their optimism and initiative. Second, many are impatient with political considerations which often take precedence over scientific or humanitarian concerns. This problem is further complicated when they feel compelled to take certain actions for political reasons which they feel are not in the public interest. They must deal with their own anger with vested political interests and with their guilt when they have been guided by political expediency rather than by what they feel to be right. Third, they must live with constant generalized attack in the form of public expressions that there are too many people on government payrolls, that government employees are incompetents who could not succeed in the business world, etc. Such attacks lead some to feel that the public does not appreciate their efforts and others to defend their own self-images. As a result, many are afraid to display initiative, and others devote a considerable amount of their time, as do people in business and industry, justifying every step they take. Fourth, because of the realities of political life, career government employees are often subject to political administrators who remain for only short-time periods and often know little about the work the career people are doing. Such temporary and "know nothing" administration makes it difficult to obtain consistent support for necessary programs and often

results in the destruction of such programs because of arbitrary decisions based on inadequate understanding. Fifth, the Civil Service structure makes it extremely difficult to supervise and deal with problem people. The rating system often requires supervisors to justify their ratings legalistically, and the process of appeal available to the employee is so complicated and time-consuming that supervisors frequently prefer to tolerate people who perform inadequately rather than to take action. Thus, many people must live with constant irritation in the job situation. Finally, as in all large organizations, there is such circumscription of functions that many people can do in their work only a small fraction of what they are capable of doing.

On the other hand, there is the satisfaction of contributing to the public good, the feeling of being dedicated to public service, the gratification of needs to be dependent in the protected structure of government, and often, despite political and administrative complications, programs are evolved that are significant contributions to public welfare.

With respect to independent workers, the problems seem to vary widely, depending on the kind of work. Professional intellectual people frequently speak of their loneliness in their work. While they have freedom to do their work in their own ways, they are all too often aware of their own limitations and their inadequate opportunities to discuss professional problems with colleagues. To a certain extent the same thing is true of the small businessman who, in addition to operating by himself, must often compete with large organizations that can draw upon multiple resources. People who work by themselves must usually live with greater awareness of their own inadequacies because they cannot so readily project their failures and mistakes onto an organization.

For independent, creative people, self-discipline seems to be a major problem. They seem to feel more keenly the pressures of their own consciences. They must compel themselves to work consistently because no one else will do so. They cannot so readily feel needed as do people in organizations on whom demands are made for production or services.

Teachers, ministers, and others who cannot measure the immediate results of their work are often plagued by doubts about the usefulness of their efforts. The inability to see the end product of their work makes it difficult for them to have adequate feedback on how well they are doing and to measure their contribution to society. In contrast to most other people, they must be able to tolerate vague, long-range,

idealistic goals. At the same time, they are called upon to assume multiple social roles which are often conflicting. A minister, for example, is expected to be a good preacher, a good administrator, a good socializer, a father confessor, and a scholar.

If a person's response to these pressures is anger or a feeling of futility, the result is chronic discontent, resignation, or withdrawal. Such behavior represents a crippling constriction. The opposite extreme—the attempt to be all things to all men—is equally self-defeating. While these pressures cannot be altogether avoided, some steps may be helpful in coping with them.

An important first step for anyone who is self-employed is to develop ways of being regularly in touch with people who have similar interests. Sigmund Freud, who worked for so many years alone and in a hostile atmosphere, carried on extensive correspondence with others who were interested in what he was doing. Small businessmen who feel helpless in the face of massive chain organization competition can combine jointly to employ consultation and specialized advice.

Those who want to work by themselves, particularly in creative functions, may find it helpful to set and keep work schedules. Subjecting oneself to such a schedule not only ensures that a certain amount of work is done regularly, but also relieves some of the guilt feelings one has when one is not applying oneself to a task that is important to the individual.

Those who must deal with intangibles would do well to establish more immediate interim goals that are recognizable steps on the road toward the distant goal. They should also recognize that they cannot see day-to-day progress toward these goals and that they can measure their progress only by looking back to see what changes have occurred.

No problem is insurmountable. No competitor is omnipotent, and no person is himself all-powerful. The person who works independently must define for himself those things he does well and focus his efforts on them. The independent businessman can do some things that the less flexible larger organization cannot do. He then can compete best on his own ground. The minister may be a better preacher than a counselor. He may take pride in his preaching, but he need not apologize for his counseling. Such realistic perspectives help assuage guilt feelings and that loss of self-respect which is in the end self-defeat. A basic tenet of mental health is realistic appraisal of oneself.

Whether working in a governmental structure is better than working alone or whether working alone is better than working in a business

organization, from the point of view of mental health, depends on the personality of the individual involved. Some people have the patience to cope with the complexity of government; some do not have the self-confidence and the self-discipline to work by themselves. What is one man's stress is another man's pleasure. Any work environment is healthy to the degree to which it makes it possible for people to use their energies for productive and creative purposes rather than in defensive maneuvers and interpersonal frictions.

WORLD MENTAL HEALTH

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Interdependence

Today every man and woman who reads and thinks about the present and future of world society may well feel that "the world is my parish." Newspapers and television keep us alerted to this. The development of the United Nations, the amazing overseas generosity of the United States as well as of other nations, are but two indications of the interdependence of the whole world. Whether we look at this from an economic, social, medical, or political point of view, there is no doubt that the times in which we live challenge us to understand and help with the problems of our neighbor countries throughout the world. Wherever we may live, the probability is that there is no country in the world farther than thirty hours from our own airport; by telephone we can speak to persons in any country in a few minutes.

The rapidity of communication, the welcome and growing knowledge of other cultures and problems, the sense of responsibility for improving the quality of living in other countries as in our own, lie behind all these remarkable activities of the postwar years. The United Nations, with more than a hundred sovereign states in its membership, despite its frustrations, can and does do a great deal that is beneficial.

It is well to remember that although the United States regards mental illness as one of its greatest problems, there are other countries that have, and talk about, the same problem. Everywhere, mental illness is regarded with increasing concern and in many countries is recognized as the biggest and most important unsolved problem of medicine and sociology.

In considering mental health throughout the world, we can learn from the least privileged of our neighbor countries, and they can learn from us. The problems of our families, hometowns, and our nation come into better proportion when, from time to time, we raise our sights and see what is happening in other parts of the globe. There is truly an interdependence with which we should be concerned.

World Psychiatric Illness

No country in the world has as yet any reliable statistics from which we can give a scientific assessment of the increase in mental illness and emotional instability. As a result, there are great difficulties in coming to the point where we can make comparisons between the actual incidence of illness in different areas and in different levels of society throughout the world. There is, however, a great deal of evidence to suggest that the incidence of mental illness (psychosis) is much the same in every country. Those who suffer from certain types of mental illness may, of course, have symptoms that are related to the culture of the country, but fundamentally the numbers of those likely to develop schizophrenia, for example, do not seem to vary greatly in any given population group.

We are constantly told of an increase in the amount of anxiety and neurosis throughout the world, both in the highly organized countries and in the developing countries where there is a great dearth of trained personnel to deal with these matters. Why should this be? It is understandable that in the changing culture patterns of any country, psychotic conditions may appear to be occurring more frequently, but the probability is that they are merely being recognized more often. Previously, persons who had such conditions could be kept hidden away in the large family or tribal groups.

The commonest cause of pathological anxiety (as opposed to normal anxiety, which we all have, and should have, at times) is the fear of failure. As we look at the development going on all over the world, it is fairly clear that this fear must be stimulated by the changes that ensue from that development. We must remember that more than half the total population of the world has always been hungry, and still is. The hungry used to think of this situation as a fact of life, the will of the gods; but with modern communications it has become clear to people that their lack of food is not due to a divine plan, but an economic and planning failure, and therefore can be remedied. This has been a factor behind the great movement toward nationalism. In consequence, the entirely laudable struggle to raise the standards of living has begun, and help is being given by the United Nations, the United States, and other nations and organizations.

Better communications, new industries, and mechanized agriculture seem to bring with them stresses that lead to anxiety. People ask themselves: "Shall I get a job?" and "Shall I be able to keep this job?" Both

questions are pertinent in view of the fact that there is often an almost unlimited labor market.

Although the husband is bringing in money, his wife, too, may go out to work to supplement his earnings and thereby help to supply the urgent needs of her family. In townships in South Africa, for example, we are told that in many families the mother and father are working away from home for twelve hours; meanwhile the house is locked for fear of burglary. The children are at school for, say, four hours, and must spend the rest of the day in the streets until the parents return.

Social Dislocation

One consequence of social dislocation is that the joint or extended family system, which has existed for some time in Asia, Africa, and Latin America, is beginning to break down, and the security that this large group of relatives, or the tribe, used to provide, is no longer available.

Furthermore, in many areas of the world there is added strain in moving from an economy based on barter to one based on money, and this, too, may produce anxiety. What we call "keeping up with the Joneses" tends to become a factor in all developing countries.

Learning from Overseas

We who live in industrialized countries can learn from situations that arise in less developed countries. It is interesting that Kwame Nkrumah of Ghana four years ago asked the United Nations for the loan of an anthropologist to spend six or more months in the bush area of this African country, to tell him what would happen to the social health of the people if, on the completion of the big Volta River Dam, electricity were supplied to the area. Here was foresight that is worth noting, for even countries with more "know-how" do not always study the social and economic effects before undertaking great alterations.

There are, of course, multiple causes for all illness, and these may be inherited, psychological, sociological, or environmental. In any country, all these points have to be taken into account.

What are we to advise the mental health workers and the statesmen and planners of the less privileged countries to do about this rising tide of stress and anxiety, which inevitably must lead at times to social and industrial unrest? Some of these countries have practically no physicians, and many of them have no psychiatrists. There are only four or five trained African psychiatrists in the whole of Central Africa.

Everywhere there is a shortage. Until 1960, Nigeria, with a population of 34 million, had only one trained psychiatrist. The same situation existed in the Sudan, which has about 20 million people. The only country that seems to have an abundance of psychiatrists is the Soviet Union, where the problems are very similar. It is said that in Soviet mental hospitals, apart from the area and outpatient services, there is one trained psychiatrist to every twenty-nine patients.

There are good and bad mental hospitals in every part of the world. Every country has need for improvement, and this will continue for many years, despite the revolutionary changes in the effectiveness of treatment in mental hospitals. Improvement in treatment is partly the result of modern methods—electroshock, tranquilizers and other drugs, and the increase in psychological treatment that can be provided in most mental hospitals. It is probable, however, that a much bigger factor has been the provision of more and better trained medical and nursing staff, and the much greater interest and individual respect given to patients, who no longer are neglected numbers in a big ward, but are recognized as individuals with families, jobs, and experience prior to their breakdown. It has been said: "Care of the patient begins with caring for the patient," and this is demonstrably true in mental hospitals all over the world. The removal of bars, restricting walls, and locks on the doors of the hospital is not just a modern quirk or a return to a much older pattern of hospital care; it demonstrates conclusively that people can be helped much more effectively if cared for as individual patients rather than if regarded as prisoners.

The introduction of day hospitals, where patients can be treated during the daytime in a pleasant and welcoming atmosphere while living at home; the reduction in the size of mental hospitals, where the optimum number of patients should be between three hundred and four hundred; and other social changes have led in many countries to the much greater demand for earlier treatment and to the rapid return home of about 70 per cent of patients.

In Usumbura, the capital of Ruanda Urundi in Central Africa, all patients who had psychiatric breakdowns have for more than a dozen years been treated in the wards of the general hospital, with no locks or restrictions, and the results have been excellent. Thailand has first-rate mental hospitals, with open doors and well-trained medical and nursing staffs, and results of treatment have been excellent. In Costa Rica the main mental hospital is excellent. In Barbados the mental

hospital has had its doors open and its outer walls down for about twelve years.

These are real advances, and it is highly important that, as a result, the stigma of mental illness is diminishing. But there are still bad, overcrowded hospitals all over the world. Many hospitals are much too large. The modern trend is well demonstrated in Denmark, where, as the result of a very careful three-year survey, the decision has been taken that all new psychiatric units shall contain no more than three hundred patients and shall be placed inside, or with covered communication to, one of the area general hospitals.

In all countries there are points of common interest and interdependence. The United States, like every country, owes much to the research-minded people in Europe, Asia, and South America, whose work has led to the development of electrical treatment, insulin treatment, lobotomy, pharmacotherapy, occupational work, and many other of the valuable developments that contribute to this therapeutic revolution. We should not forget that *Rauwolfia serpentina*, the plant root from which the tranquilizing drugs have been developed, has been in use for eight to nine hundred years in India.

Further, we should not forget that folk medicine has produced the traditional healers of African countries and many other places. Such healers have skills in dealing with mental illness, and through abreactive techniques of dancing, trances, etc., plus the use of much accumulated common sense, do much good for large numbers of their patients. We should help them develop their knowledge and techniques, and not discard their work as "mere witchcraft."

Mental Defect (intellectual subnormality)

In every part of the world it can be assumed—in the absence of statistics—that the number of children born with this handicap is similar. Perhaps under difficult conditions fewer survive into adulthood.

In many countries there have been exciting research results that suggest a breakthrough in the early treatment and prevention of some of these conditions. Still more important is the increased sense of responsibility for the care and special education of these children. In many countries the dynamic interest of parent groups is creating a vast change toward hopefulness and social and intellectual improvement. Much, however, remains to be done.

In the underdeveloped countries it would seem almost impossible to provide adequate treatment for all those who need it, either in hos-

pitals, day hospitals, or outpatient clinics, although every possible effort must be made to do this. The long-term policy must, however, be one of prevention, and here we need to know a great deal more about how to prevent mental illness and how to build up optimum mental health and capacity to withstand stress.

This is a problem that should be placed directly before the people in developed countries. We have plenty of problems of our own, but one of the justifications for spending time, effort, and money on research, training, mental hospital care, and a score of other activities is that, out of all this, we should be able to distill information that indicates how some of these conditions might be mitigated and some of them prevented altogether; and much of this could be applicable, with some adaptation, to countries that are sorely lacking in trained personnel and up-to-date information.

In this matter we should think not only of psychiatrists and physicians, but also of psychologists, social workers, nurses, clergy and, above all, teachers. If more people were to ask themselves: "Why did this individual become ill (or difficult, or awkward) as he did and when he did?" we should begin to accumulate a body of information with which we should be able to design and carry out some preventive measures for use in our own countries, as well as for use in less developed countries.

All of this is of importance to every person who is concerned about mental health. It suggests a responsibility that all of us share for doing something locally and, at the same time, keeping in mind the needs of people in many other parts of the world who have less education and fewer facilities.

Problems of marriage, child rearing, and work are universal ones; mental health is the world's concern.

Lack of Cure-alls

A panacea could never exist for all the problems of mental health. Intelligent interest based on love for human beings is the most important thing we can provide. Psychoanalysis is exceedingly useful as a discipline and a technique for the training of psychiatrists and for the intelligent design of research; it is also, of course, useful for treatment in a certain proportion of illnesses; indeed, it may be essential. Psychoanalysis, however, might become too popular and be regarded almost as a substitute for psychiatry and for the social thinking of psychiatry. From the economic angle and the manpower angle, the question of

whether psychoanalysis as a therapeutic agent can solve the problems of world society is hardly worth considering.

We need a comprehensive psychiatry that takes full note of the environmental and social factors, as well as the individual and psychological difficulties, and for this reason the enormous variety of tranquilizers and stimulating drugs is something of a danger. Patients are being discharged from mental hospitals because their more marked symptoms are masked by the drugs. In many cases patients leave before they have really had the help that they might have received if they had remained more accessible to therapeutic contacts. They create a problem for their families and a high rate of readmissions to hospitals.

These drugs are extremely useful when properly used, but they are not the answer to problems of mental hospital psychiatry. There is a considerable danger that, when used in areas where there are very few psychiatric or social facilities, the drugs may give the appearance of stemming the tide of mental illness; whereas in actuality, the illness may at a future time return and be more difficult to deal with than before the administration of the drugs.

Public Education

It used to be thought that public education, either through lectures or the reading of special literature, would put people in a position to deal with their own difficulties and the problems of their children. This has been a somewhat disappointing approach, although, of course, there are groups of better educated parents in every country, who can learn a great deal from some of the excellent books and special documents dealing with child rearing. Public lectures and the use of audio-visual aids certainly make people more aware of their problems and consequently increase the waiting lists of available clinics, but it is very difficult to be certain that such methods really accomplish a great deal that is permanent. Small discussion groups are much more effective.

The most fundamental educational work may be done by the family doctor and the public health nurse, who are highly respected by parents and children. As we get better educated physicians and nurses who gain insight into the environmental and psychological problems that affect children, it seems probable that they may provide the bulk of first aid in this field. Their example in the handling of babies and small children, and their readiness to listen to the problems of the home and to give simple advice, could have a lasting beneficial effect on the management and upbringing of children.

Better understanding by teachers of the problems of human relationships, the facts about race, and the needs of individual children who do not quite fit into the general "normal" group, will ensure that there is wise handling of small children in school. There is great need, both in the developed countries and those countries in the process of development, for encouragement of this type of action.

Professional Education

Professional education is one of the great problems that needs to be tackled everywhere in the next decade. Psychiatric treatment or wise psychological care and help can very rarely be given effectively by people who have no knowledge of the language or of the cultural background of the people with whom they are dealing. Training schools, not only for doctors but for all in the human sciences, including education, must be developed, and preferably in the country of the trainee's origin and language. The wealthy countries can help, financially, to train some of the mature teachers from the underdeveloped countries and eventually to make adequate facilities available everywhere in the world. It is surprising how many places there are in the world where there is only a minimum amount of time spent on the psychiatric training of those who are going into general medical practice, and where in many cases there is no training in this field for nurses or for social workers.

On the other hand, there are very encouraging situations to be found in many countries. We know much about experiments of parents looking after their sick children while they are in hospitals. These experiments have been carried out in the United States and in Great Britain, but one also finds in Yugoslavia, Africa, and Asia, children's hospitals where practically all of the nursing is done by mothers who come and live in the hospital with their sick children, providing a real education, not only in the simple application of modern scientific techniques and methods of living, but in the fundamental necessities of love and security for the children. Where this happens, the children themselves have a much better chance of rapid recovery; and the actual procedures learned in hospitals are eventually spread from person to person back in the villages or in the streets of the city, so that many other children are given a better chance to get wise and sensible care. We need much imagination and common sense in devising extensions and variations of this approach to the rights of the small child.

For the child who is emotionally disturbed, or in some way difficult, the counseling clinic of the school, or other agencies, where parents can be given guidance, have apparently achieved a considerable success. We have far too few factual studies of the results achieved, and sometimes we may lose sight of the need for evaluation, in our concern for the vested interest of child guidance. We could learn something from countries where life is extremely simple, and where there is no possibility of elaborate buildings, staffs, and techniques.

One can, for example, cite a small town in Costa Rica where there is a large children's clinic that has been extremely effective for several years in dealing with all the problem children of the town, and which is run almost entirely by the devoted teachers of one of the schools, at no cost to official funds. They have some help from a psychologist and a psychiatrist, and have learned very successfully how to deal with the different types of problems brought to them.

The Individual and World Mental Health

The individual can begin at home with the many things that need to be done. If in your area there is a mental health society or some other group concerned with mental health problems, you can join it, not merely to give financial support, but also to give interest and work, contributing something to better understanding and management of some of the local difficulties.

By being a "friend" of a mental hospital, you can do valuable work for lonely patients or for those just discharged from a hospital, and you will get an insight into the major unsolved problems of mental illness.

School medical services, delinquency, alcoholism, infant welfare and well-baby clinics, problems of the aging, and needs of students, whether they are from your own country or from overseas, are a few of the many areas in which an individual can, with modesty and patience, learn to be helpful.

If there is no local association, you can get together a few of your friends to discuss these matters, and out of their interest there may well grow a group that can work in conjunction with public health and other official agencies. Professional and academic people will be helpful. This is a form of on-the-job training that is useful and provides practical experience with problems that vex the whole world. It leads to better understanding of ways in which these issues can be dealt with in our own and in neighbor countries.

Try to ensure that any activity undertaken in your area is carefully

planned, if possible with the help of some competent professional person. A method of evaluation should be devised so that you may eventually know if what you have been attempting to do has, in fact, been effective. This is how we learn what we can pass on to other people who have fewer facilities and less knowledge.

The reading of books may help. Seminars and discussion will certainly give better insight—the amplification of one's own common sense.

However, before we try to help with the problems of other people, it is a good thing to take a look at ourselves. If we are authoritarian or bossy, if we are people who enjoy interfering in other people's lives, if we have somewhat eccentric ideas, or if we are merely trying to work out some of our own difficulties by studying other people, we shall not be very good workers in the field of mental health.

Preventive Action

A good instance of this has come from Israel, where one man, a judge, became concerned about the effect of court proceedings on children who had been sexually assaulted. Those who have worked with children know that such an experience can produce extreme anxiety, and also that the obligation to appear in court and give evidence, even though one is the injured party, gives rise to feelings of guilt. This can lead to difficulties in relationships with the opposite sex in adolescence, to unsatisfactory personality development and frigidity of character structure, and often to sexual frigidity.

By Israeli law, a child who has suffered an assault is not allowed to appear in court. A social worker takes a full history from the child, thereby relieving the child of much anxiety, and then appears in court to give the child's evidence. This has been a highly successful experiment, and no case of apparent injustice to the offender has been recorded, despite the acceptance of "hearsay evidence." Careful observation of facts, with imagination and planning, can provide beneficial legal action.

The individual citizen, lay or professional, can usefully interest himself in the problems of other countries and cultures by reading and by observation when traveling.

The documents of the World Federation for Mental Health and those of the Mental Health Section of the World Health Organization can be of value in learning about mental health problems in other countries.

International Tensions

It is not always realized to what extent faulty attitudes contribute to the development of tension between nations. These matters need study and action in a score of different ways, and none of them are so remote from the life of the ordinary citizen that we can avoid some responsibility for them. Fear, jealousy, greed, inertia, ignorance of language and national cultures, and many other matters, help to create the difficulties that make it so hard to live together in "one world." Everywhere we find considered beliefs about what is right and what is wrong, and we surely should stick firmly to these, but we do need more insight, understanding, and tolerance of the differences in point of view. It is neither possible nor desirable that everyone in the world should think our way in all matters.

Name-calling and abuse of peoples of other nationalities are sure ways to promote the sense of tension between countries. Most of us know from experience that if we are rightly critical of a child or an adult when he does something antisocial, we are most likely to help him if we can be critical on that point but at the same time show that we recognize his good qualities and that we can still be friendly, even though it has been our job to disagree strongly with him and perhaps to punish him. For example, the child or the adult who has been criticized but given no assurance about friendliness or respect, is almost certain to reject the whole of the criticism because he feels that the person who criticized sees no good in him. The reverse happens if the attitude is one of kindness and respect. It is a true saying that we can hate the things that people do, but not hate the people who do them.

The ordinary citizen, therefore, can perhaps induce his local press to stop using offensive words about people with whom they disagree, and this can produce an effect far beyond the local area. To be specific, it would help greatly if we in the West could discourage people from talking of "*red* Russia," or "*red* China," or bandying about the word "*communism*." Used in certain ways, they can be insulting words. We must try consciously to avoid stereotypes or pictures in our minds that all Germans, all British, all Americans, or all Russians, are of one type. Of course they are not.

Those who serve on committees, in local government, or on other official bodies, can well try to deal with some of the tensions, and to get agreement by consensus, or at least try to achieve a tolerant and real understanding of different points of view. There is room for experi-

ments in conciliation (which is a strong and not a weak thing) in every area of work.

In one of the United Nations meetings a psychiatrist, who happened to be in the delegation of a Western government, heard the very caustic and aggressive reply that had been drafted by his delegation as a reply to a statement, which they knew was going to be delivered that morning by two of the Socialist Republics. He said: "You can't do this sort of thing. If a man in my office is aggressive to me, I am not aggressive back to him. It doesn't work." After much argument the delegation accepted his point of view, and on their instructions he wrote a new speech for his chief delegate, which was honest, tolerant, and friendly, and the human relations of that three-week meeting were greatly changed.

There have been many such experiences, and we are right in believing that those who are interested in mental health can do a great deal in this wide and extremely important field of disputes and discussions among groups and nations. In the 1600's, a great chancellor of Sweden wrote: "You have no idea with what little wisdom the world is governed." Since this is still true, we need to try to add something to the available wisdom.

International Activities for Mental Health

Clifford Beers in 1908, with the help of a number of distinguished psychiatrists, established the first Mental Hygiene Society (Connecticut) in North America. The term "mental hygiene" had been used before that, and in different countries there had been groups of people interested in mental health problems, but there was not much linkage of their efforts.

From 1908 onward, the movement, which had first aimed mainly to improve the mental hospitals, spread in North America and stimulated similar activity in many other countries. In 1930 the First International Congress on Mental Hygiene was held in Washington, D.C., by the National Committee for Mental Hygiene and this led to considerable development of interest throughout the world. Soon after this, Beers started the International Committee for Mental Hygiene, which called another congress in Paris in 1937.

The mental hygiene movements in most countries tended to be represented by perhaps too large a proportion of psychiatrists, because the awareness of the need for interprofessional thinking and activity had not then developed. World War II disturbed most of the countries

of the world, and at the end of the war, when it was decided to try once more to bring together all the people who were interested in this particular mental health approach, the United Nations and its specialized agencies had just come into being. The United Nations Educational, Scientific, and Cultural Organization (U.N.E.S.C.O.) and the World Health Organization wished to create an international nongovernmental organization that was more broadly based, representing people from all the human sciences. The result was that at the Third International Congress on Mental Health in London in 1948, the World Federation for Mental Health was inaugurated.

The federation, which includes more than 140 professional or mental health societies from forty-four countries, has been as active as its financial situation will allow. It has conducted international study groups and expert committees, international teaching seminars, annual meetings and congresses, and it has had close contact with those working in this field in approximately ninety-four countries. The World Federation for Mental Health has about thirty-six member associations in the United States, many of them national, state, or local mental health bodies. The larger associations in the human sciences are also members. It still is the only widely based voluntary organization in the international mental health field, and, as one of its many activities, serves as a clearinghouse of information.

The World Health Organization of the United Nations by its constitution is devoted to the pursuit of physical, mental, and social well-being. It is, of course, an intergovernmental body, whose members are governments. Its Mental Health Section was organized the year after the organization of the World Federation for Mental Health, and is very active. It has convened a large number of international expert committees, which have produced reports that have been read and acted upon by governments and professionals all over the world. It has been able to supply many consultants, at the request of countries, and to grant many fellowships for training. The Mental Health Section of W.H.O., with which the World Federation works closely, serves also as a collector and disseminator of information.

U.N.E.S.C.O., through its Departments of Education and Social Science in particular, has also made a distinguished contribution, in the international field, to what it usually calls the social and moral issues. It has done much work on the subjects of education and race and on the question of international tensions and the difficulties of international

living together, and has produced a considerable effect on the thinking of teachers, sociologists, anthropologists, and others.

The World Federation for Mental Health has official relationships with U.N.E.S.C.O., as well as with W.H.O., and also with the International Labor Organization, with U.N.I.C.E.F. (United Nations International Children's Emergency Fund), and the Economic and Social Council, and has permanent observers who attend meetings of all these bodies. Apart, therefore, from the federation's own activity, it has a wide perspective on many other efforts and is able to add support to many of them.

YOUNG ADULTHOOD

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What is young adulthood?

Legally adulthood starts with the statutory age of responsibility. This may occur within the age span of fifteen to twenty-one years depending upon local variations in laws. In the general sense of personality development, adulthood is the state of maturity beginning usually in the early twenties and including middle age and old age. Young adulthood is the decade of the twenties and in recent years has been described as a time of transition to full maturity. No doubt this transitional period is the result of social and economic trends that have encouraged prolonged training and education and discouraged early marriage. In effect, this has postponed mature adulthood, at least in the social sense, for many young people. Physiologically, physically, and emotionally, young adulthood marks the emergence of the total personality pattern. Thus, for the first time in the life of the individual, complete and integral functioning is possible.

How many people are there in this group in the United States? How many women? How many men?

In 1960 there were approximately 34,232,000 people in this country between the ages of twenty to thirty-four, of which about 17,063,000 were men and 17,169,000 were women. Thus, there were roughly 100,000 more women than men in this group.

Do these rates differ from those in other countries? Why?

There are slightly more men than women in most Western countries in this age-group; but in recent years this has been changing. As industrialization, higher standards of living, and better medical care become more widespread, one expects to see a decline in the female mortality rate. Thus, as in the United States, there will soon be a greater number of women in other countries too.

Are these rates changing? If so, why?

Yes. The number of young females has been steadily increasing since 1900, due to the declining female mortality rate and the change in immigrants from predominantly male before 1930 to predominantly female, especially since World War II. At the same time, the majority of people emigrating from this country are men. Thus, the ratio of women to men has been increasing, because fewer women die at earlier ages and more women come into the country while more men leave it.

How much influence do the experiences of the early years have on the young adult?

The experiences of the early years exert profound effects which later can be modified and sometimes reversed. That the early experiences of life, external as well as internal, real as well as imagined, have special impact upon later development is a basic notion in most theories of personality development. The process of personality growth is uneven, that is, the rate and effectiveness of development in different areas are variable. In the early years personality growth and emotional maturation are characterized by the ebb and flow of impulses and feelings that may function in harmony but may also be in discord. At times certain impulses are stronger than others, and sometimes only a part or segment of an impulse may be operative. Eventually these so-called partial impulses fuse, evolving finally into characteristics of the adult personality. For example, early sexual impulses such as love of oneself (narcissism), love of others of the same sex (homosexuality), and love of those of the opposite sex (heterosexuality) appear and disappear in cycles and phases in the course of psychosexual development. Adult heterosexual feelings represent a composite—a fusion of these immature impulses.

Early influences are woven into patterns of emotion and behavior, some of which may be characteristic of the young adult. These influences may promote personality growth or impede it. The patterns represent life themes which develop around experiences that occur in very early childhood. The themes are often deeply involved with parental and sibling relationships. As basic patterns they may be repeated throughout life, sometimes very obviously, as in the excessively neat person, at other times very subtly disguised and camouflaged, as in the erstwhile criminal turned lawyer. We see something of this in the adult who is competitive or aggressive to a fault. He may have

grown up in a family in which he had to struggle too hard for attention, in which he had to compete too much with brothers and sisters for a share of parental love. Another example of the adverse effects of early influences occurs when there is abrupt or prolonged separation of children from parents without adequate and early substitutes. Unless such absence is compensated in childhood, the adult may experience inexplicable fears and anxieties in the face of real, imagined, or potential loss, or he may even experience difficulty developing adequate emotional attachments. The positive effects of such early influences as love, security, understanding, discipline, and trust cannot be overestimated in the stable, effective and affective (emotional) young adult who is zestful, vigorous, and reasonably happy.

What are the typical attitudes of the individual approaching young adulthood?

There is a great variety of attitudes in the young adult group. Indeed, within any given individual there may be a broad range of attitudes, some consistent and some paradoxical, so that generalizations here as elsewhere are difficult and run the risk of inaccuracy.

In the young adult, unconscious and conscious forces are especially interactive. Attitudes of self-examination, self-definition, and self-criticism are commonplace; the young adult has questions about ambition versus fear of failure and success, about desire versus self-discipline. He is concerned about proper goals and his potential for achieving them, and he is worried about appropriate opportunities to do so.

In many young adults there are remnants of late adolescent rebelliousness, of anti-authoritarianism, or at least of some persistent challenge to the status quo. But in contrast with adolescence, there is now a clear shift toward realism. If any attitude is typical, it is the young adult's eagerness to take on responsibility first for himself, and then for others, and for society. In short, it is the attitude of independence. Young politicians are the firebrands; the young man who works for his father wants to change things around a good deal; the shipping clerk has strong feelings about how the president should really run the company; and the young mother may interpret her mother's or mother-in-law's advice on child rearing as undue interference.

Eagerness to marry and take on family responsibilities is quite predictably common in young adults. So is a certain degree of optimism and excitement, as well as anxiety, in dealing with the problems that these responsibilities bring with them. The young adult is very much

concerned with making value judgments of himself, of others, and of social institutions. He sees and decries hypocrisy in business, in government, in education, and in society in general. He recognizes the need for high and clear standards of behavior for himself and his family and for those in significant public positions, and he frequently identifies himself with those who represent the moral forces in the community. He often wants to go to "city hall" to get his rights, so to speak. But such idealism may not keep him from a reasonable or even expedient compromise with external pressures such as the need or opportunity to make money.

The healthy young adult is an emotionally expressive person who is sexually aware and reactive. Sexual impulses and activities are at once a source and a result of some of his attitudes. The young adult clearly senses that authority for almost all of his behavior has shifted from others to himself. This brings him a sense of control that is new and probably best symbolizes his status as an adult.

What are the special challenges and stresses of young adulthood?

In a major way, the young adult is challenged by expectations. It is particularly urgent that he fulfill those expectations he has and has had for himself, perhaps for many years, and somewhat less urgent that he fulfill those held out to him by family and friends. This requires, among other things, serious commitment to family and job or career; acceptance of risks, especially in work situations; investment of long-term effort; and the capacity to accommodate immediate wants to long-term satisfactions. In adulthood waiting is unavoidable, and waiting breeds anxiety and tension. To meet this without undue restriction upon daily tasks, or without interruption of ordinary responsibilities, is probably a daily challenge for most young adults. Tasks or activities that bring rewards readily are often effective antidotes to the anxiety and frustration that most people feel when their just rewards are not readily forthcoming. To counteract such anxiety, at least partially, the mature young adult engages himself in hobbies such as sports, collecting things, or handcrafts, or in avocations such as creative arts, shopwork, or participation in programs of fraternal, social, charitable, civic, or church organizations. Such activities also help the young adult meet the challenge of finding some balance between the necessity of earning a living and the requirement that he assume his fair share of responsibility in community affairs.

Whether and for how long to postpone sexual activity and/or mar-

riage is especially challenging. The responsibility for setting one's own limits in the face of strong physiological (sexual) impulses that are at or near a lifetime peak of intensity, is both a stress and a challenge of great immediacy. Our preoccupation with economic security results in prolonged dependence on family and has delayed marriage in many instances. Such postponements place special stress on the young adult. His physical and emotional development press him toward intimate relationships while, at the same time, his moral or ethical code may forbid premarital sexual activity. The conflict of guilt and frustration may be severe in this situation. The challenge of accommodating behavior and social life to emotional and instinctual forces is really the challenge of developing adequate controls at many levels of reaction, but especially at the level of physiological impulses. The young adult becomes emancipated from regulation centered in other persons at a time when his inner impulses are strongest. Thus, he is set free to deal with himself when, in a very real sense, he is most vulnerable to himself. He then faces the challenge of becoming responsible while physiological and instinctive (sexual) forces which may make for irresponsibility are at their height. Basically, the challenge is that of establishing effective self-discipline, of imposing one's own order on one's own capacity for disorder.

Marriage is, of course, a multilateral challenge for all young adults. To marry for realistic reasons, that is, for emotionally and socially valid ones, is one important aspect of this quite special challenge. The temptation to restrict marriage to the passionate and romantic, even to the predominantly physical level that may have existed in the beginning, is illusory and must be recognized as such. Marriage of the movie or television sort does not occur often in everyday life. Another challenge of marriage is that the young adult must learn how to grow with his or her spouse so that both partners nurture the marital relationship and each other. Thus, they may ultimately find something in marriage that is more than the sum of its partners. All adults need to recognize the enormous challenge to patience and acceptance that the close day-to-day living of marriage requires.

Rearing children is a challenge that comes only with adulthood. The problems of parenthood, often enjoyable, are myriad and complex. To meet these healthily, fathers and mothers need reasonable understanding and control of themselves. They must be able to focus attention and affection on children rather than on themselves, deriving satisfaction from giving support rather than gaining direct reward. It is

essential really to want children before taking on the challenges of parenthood. From the start parents are models to children, models in almost every sphere of reaction, behavior, and attitude. Parents need to be aware of this nearly all the time and particularly during a child's early years. Parents bear a clear responsibility to their children for being constructive models of reasonable behavior and appropriate values.

In American society there are unbounded opportunities for greater and greater accomplishments, and vast rewards in material things as well as in prestige. These are powerful incentives but they also produce steadily increasing pressures on young adults to exert themselves to the full, perhaps even to aspire to goals that lie outside their capacities. It is a real, but subtle, challenge for the young adult to adjust his goals realistically to his capacities in a society that tantalizes with many promises, implicit as well as explicit, but in which values are often fuzzy and conflicting.

Are these challenges and stresses different today from those in the past? Are they in the process of change? Why?

They are probably not very different, except in their social aspects. We live in a period of general as well as special social change and unrest, that is unusual if not unique. Long-established socioeconomic systems, customs, institutions, and concepts are undergoing extraordinary alteration or are being discarded altogether. A world of great mobility, of automation, of complex devices for universal communication, of political and economic turmoil, is a world of anxiety and change almost by definition. Indeed, this has been called "The Age of Anxiety." We are seeing major increases in population. There is a proliferation of mechanisms and devices for dealing with man in the mass, such as ubiquitous agencies and functions of increasingly centralized government, the huge metropolitan area, as well as the huge suburban area, supermarkets, and large academic and medical centers. These have developed in many people a sense of depersonalization, of separation from the forces and people in society which critically affect their lives. Such social metamorphoses are stressful and challenge people of all ages. Young adults feel this challenge particularly because the changes are most marked at levels of society in which they are most involved.

For several generations young people, at almost all social levels, have

been encouraged to avail themselves of higher and higher levels of training and education, so that the rewards of a highly complex and unmistakably affluent society might be more accessible to them. At the same time early marriage and young families have been discouraged. This particular trend has been especially true in the middle and upper-middle socioeconomic groups in which great value is placed upon long periods of "becoming" through extended preparation. In such groups the academic degree has become an almost essential symbol of status. At lower socioeconomic levels a degree, diploma, or certificate is often seen as the *sine qua non* of recognition and reward in a society that is very conscious of education, social esteem, and money. In very recent years there has been a trend back toward early marriage and quite young families, especially among those of higher intellectual levels. It remains to be seen whether or not this reversal will endure.

Much could be said about the impact of atomic energy in its peaceable and military uses upon the young adults of our time. This is a confused matter about which little is known, but which generates unmistakable anxiety. Though there is still much disagreement on the subject, this writer is convinced that both the threats of destruction and the promises of utopia to be brought about by atomic energy have had serious effects on the values and especially the mood of today's young adults. These threats and promises impinge upon such an extraordinary range of experience and importance to young adults that they may represent the greatest stress and challenge in mankind's history.

How are these challenges and stresses usually met by the young adult?

These challenges can only be met in the total context of an individual's life pattern in ways that respect his moral, emotional, social, and economic circumstances. These are sensitive and individual matters requiring deep insights and complicated judgments. Experiment and education often help young adults to deal with their problems. For example, to meet the job or career challenge, the young adult may try his hand at different occupations until he finds something that offers him personal satisfaction and proper rewards, and in which he can exercise his skills and talents effectively. This experimentation with work and himself is often aided by education, formal or informal, in an effort to further develop his capacities. After sufficient experience, it becomes conceivable to eliminate certain possibilities and to narrow the field to a single work situation that is a reasonable compromise of

the type of work, salary, location, and the other criteria of the ideal job. Most young adults are engaged in meeting the challenge of a career in some such manner, whatever their degree of skill or talent, even though in many instances the process is not evident. Young adults also seek advice and help when needed, e.g., when decisions are too difficult to make, when motivation falters, or when repeated experimentation fails to lead to a satisfactory way of earning a living. Help may take the form of counsel with the family or friends, or on the more formal level, with a religious adviser, teacher, vocational guidance person, social worker, or doctor. It is important to recognize when help, professional or otherwise, is required and not to hesitate to seek it. Young adults are usually quite perceptive in dealing with problems and often show better judgment in seeking help than do their elders.

What are the essential characteristics of this period for men and for women?

For both men and women this period is characterized generally by autonomy of choice and action and assumption of many responsibilities. It is a time of physical and physiological maturity, of keen social awareness, and a time when the personality reaches its full integration. More specifically, love, courtship and marriage, establishment of a family, and a peak in sexual activity and expression are characteristic. For men, career and family support are the important words; for women, the home and family care. For both, this period is essentially characterized by the problems of personal commitment. Men, especially married men, devote themselves to a job or career in which they find comfort and satisfaction, a job which is stimulating and offers the promise of compensatory rewards. For a woman, the building of a home, rearing a family, finding satisfactions and pleasures in the routine and usual experience of the family become the life to which she devotes herself thoroughly, though not necessarily exclusively. Of course, some young women attempt to develop both career and marriage simultaneously. Eventually, however, most women find that one of these becomes predominant, and that preferential commitment to one or the other must be made or neither will be satisfactory. Every young adult learns to establish a priority of activities in accordance with his values, his energies, his feelings, and his satisfactions. The woman who prefers a business life to family life will find less and less satisfaction in her home, and the home will suffer. The man who struggles with a job just to earn

money, or to be "successful," who in fact has real interests in some other form of endeavor, will find himself doing less well on the job than he would like to do. Or he will show other evidences of his unhappiness and dissatisfaction, such as being difficult to live with at home, overeating, or overdrinking. The young adult who finds his niche in life, who "finds himself" in terms of job or career and family, achieves an individual identity that is both privately and publicly recognizable. Family relationships define his role at home. Business and career relationships define his role in public. Both characterize the individual who begins to function with an inner sense of harmony between himself and his life experience, between himself and other people, between himself and his environment.

How do these characteristics differ in certain economic groups? Higher intelligence groups? Religious groups? Urban or rural groups?

There are some noticeable but perhaps superficial differences, especially in the social and sexual realms. Higher economic groups may sanction or even encourage delays in career choice and in embarking on marriage, especially in urban communities. This may prolong dependence upon the family and foster immaturity. In rural communities young adults probably marry earlier and settle in their work earlier. In higher intelligence groups in recent years the trend has been toward a greater involvement in social issues, earlier independence, and marriage, with or without a clear choice of career. According to Alfred Kinsey's reports there is less sexual activity in fundamentalist religious groups, in groups of higher intellectual level, and in rural communities. But patterns of sexual behavior vary greatly from individual to individual. It is important, therefore, to recognize that it is very difficult indeed to make adequate studies of people's sexual customs, habits, and experience. Even Kinsey's material, exhaustive as it seems to be, leaves room for many questions. But at least it can be said with reasonable assurance that widespread sexual education, together with intense social and economic pressures, have led to a very real rebellion against turn-of-the-century value systems. Almost all young adults have by now discarded or, more accurately, have come to disregard sexual attitudes and behavior that smack of late nineteenth- and early twentieth-century unrealism and unnaturalism. Out of this is developing a moral code that is quite possibly a good deal more honest and no doubt more effective as a constructive social control.

In general what is the young adults' conception of: The family? The community? Authority? Independence? Careers? Sex? Responsibility? School? Marriage? Younger people? Older people?

These are the areas of experience and the relationships in which young adults identify and formulate their image of themselves and their role in society. The individual sees himself as being liberated from child-parent dependence and able to assume the responsibility of parent-child dependence. Thus, family relationships reverse themselves for the young adult: he gives up the dependence of childhood and adolescence in order to take on the dependability of an adult. Similarly, there is a shift in his conception of authority. The idea of greater or lesser arbitrary control over his life gives way to the concept of such control of himself that within reasonable limits permits satisfactory expression of feelings and adequate social adaptation. Sex is seen as a natural activity about which he feels freer than his parents did and much freer than his grandparents. It may play a prominent part in his reactions and behavior, and for a time, perhaps a too prominent part. Except for young adults who go on to college or beyond, school is, on the one hand, merely a preliminary to the more important matters of job and family or, on the other hand, the taskmaster of unfulfilled ambitions. But the desirability of an extensive education is a value that is becoming more and more understood in our society, especially in the young adult group.

Such concepts of the young adult reflect the dissolution of earlier ambivalences, the formulation of realistic points of view, the initiation of pragmatic patterns of behavior, and the clarification of ideals, all of which may not have been possible or even necessary before. In place of the paradoxical views of late adolescence, young adults develop an objective, comprehensive, and realistic point of view, one that has order and can be generalized. The change is one from separate and often conflicting attitudes toward a unifying philosophy of life.

What are the reasons for the difference in attitude of the young adult male vs. the young adult female?

In our society the male role is traditionally an aggressive-independent one, while the female role is a passive-dependent one. Men are concerned with the problems of earning a living, women with problems of home and family. Double standards of values often aggravate these differences, especially in sexual and social mores. For

example, the young woman who sits alone at a bar probably will be criticized, but young men have rather complete freedom to go "stag" anywhere. Especially in sexual behavior, tacit if not overt approval leads to considerably greater permissiveness for men than for women.

Emancipated from kitchen, laundry, and nursery by modern inventions, women have developed a lively interest in public affairs. This is especially true in the economic area, since women are said to control the dollar investment wealth of this country. This has led to additional conflicts in attitude, the most difficult of which for men, paradoxically enough, is the growing similarity of women's attitudes toward their own. The difficulty is related, on the one hand, to men's past expectations of women, and to their failure to give up unrealistic, stereotyped inflexible concepts of women. On the other hand, women refuse to settle for their traditional passive role. They find it possible to play the passive dependent female at home, but equally possible to be independent and aggressive in careers or jobs or even in public life. Thus, men have to accept women in an unaccustomed role. Men can rebel against women's freedom, which is a useless and hopeless task, or moderate their own behavior to more passivity, which is an unpleasant one. Indeed, some observers hold the view that overpassivity among men, as well as more female aggressiveness, is becoming a marked problem in this country. The other alternative would be for men to play the aggressive role even more strongly than before, although this is not likely to succeed widely or for long.

In a young family many tasks may be shared rather than defined. Earning a living and caring for the children may be undertaken equally by the husband and wife. The lines of jurisdiction merge and overlap. As young adults come to accept these realities and adjust to them, some of the differences in their attitudes disappear. This trend suggests that men will have to accept more aggressiveness in women and vice versa.

Another reason for the difference in attitude is the young man's desire for the stability of family life while still clinging to some bachelor freedom, whereas young women want equal competitive opportunity in the business and professional world without giving up the usual feminine perquisites. The changes in the male and female roles in our society have meant some fundamental changes in our concepts of family life. Differences in attitudes between the sexes will probably continue until such time as there will be widespread acceptance of changes and a generalized accommodation of attitudes. In the

meantime, most young adults will take comfort from the still immutable biological and physiological differences between the sexes.

In our society the social and personal pressures upon young women to marry early are significantly greater than those upon men. Indeed, in many quarters, especially in the middle and upper socioeconomic groups, delayed marriage for young men is highly approved. The joys of bachelorhood, of "playing the field," of pleasure without much responsibility are likely to be more prized by men than are the dubious joys of maidenhood by young women. Indeed, women are likely to have much more serious expectations for romantic episodes than are young men. This allows men to interpret their own resistance to marriage as male aggressiveness and women's pursuit of marriage as female passivity. An unmarried man is the subject of bemused tolerance; an unmarried young woman arouses sympathy or, in some circles, despair. But for the young bachelor who prizes his freedom, life is not unrestricted pleasure. The perennial bachelor is perennially immature; he is as much a matter of concern to his family and to himself, denials notwithstanding, as is the bachelor girl. The young adult buys this kind of freedom at some cost. For most young adults, a commitment to someone of the opposite sex is a necessary ingredient of security, of happiness, of the achievement of personal identity, of a mature sense of personal worth and value, in short, of self-respect. The satisfactions of short-term relationships, however intense, are essentially short-lived. Bachelorhood is self-defeating in that the very satisfactions it aims for become, in the long run, very difficult to achieve outside the marital relationship.

What intellectual, social, or emotional changes usually take place during this period?

This is a time when individuals begin to settle issues for themselves. They are reaching the full play of their intellectual capacities, building an effective, responsible, and satisfactory place in society, and establishing mature, long-term relationships with the opposite sex. The changes are, therefore, in the direction of establishing order, efficiency, security, and satisfaction in their lives. It is now possible for the young adult effectively to order himself and events toward his own goals, and to begin to see some return for his investment of time and effort. The change is away from the confusion and scatter of adolescence toward the efficient productivity of maturity.

How much influence do the experiences of the young adult have on the rest of his life?

The determining role of early experiences in personality development has already been discussed. The experiences of the young adult are more likely to moderate the rest of his life rather than alter it in any basic sense. Naturally, the decisions and choices one makes during this time will produce their effects later on. A good marriage versus a bad one, a congenial career versus an ill-chosen one will have direct effects upon later happiness. In our society middle age and old age are likely to be most critically affected by the presence or absence of emotional, intellectual, economic, and social reserves. These can probably be provided best by a fully active adult life.

To whom can the young adult turn for guidance and help in his own environment? Family? Friends? Other young adults? Teachers? Ministers?

All are proper sources of help provided they can listen objectively and uncritically and can maintain confidences. Teachers and family physicians are also often skillful counselors. In any case, the young adult should be wary of the person who offers advice too readily, imposes his own values, or seeks to foster dependence upon the counselor. The skillful counselor helps the individual find his own solution to a problem in his own terms. In cases of serious trouble professional medical help should be obtained.

Are there agencies or institutions in the community specifically concerned with the problems of the young adult? What is their function?

This depends to a very real extent upon the community. The greatest number of facilities lies along the eastern and western coastal areas and in the larger central cities. Some minimal facility, that is for emergency care, is available almost everywhere, even though in sparsely populated areas it may be necessary to travel some miles to get to it. Schools, churches, public and private psychiatric clinics, family doctors and psychiatrists, family service offices, and mental hygiene groups, all may offer assistance in environmental and school adjustment, job and marriage counseling, parent-child relationships, or treatment for emotional illness. The quality of such help is generally getting better, but despite the fact that more numerous facilities are available to young adults than to any other group in the population,

they are distinctly inadequate. We must have more and better of everything we already have. We need more new ways of dealing with the problems and must apply more imagination to them. More clinics and more personnel are needed and, of course, more money, private and public. Especially, more education is necessary.

The National Association for Mental Health and many local mental health and educational groups have participated in programs to increase public awareness of emotional problems and their management. Advances in the whole social science area are reflected in mental health programs, national and local. These have improved rapidly in recent years, especially through the use of television, radio, and films for developing awareness of emotional problems and mental health facilities. These programs have done much to take the stigma out of emotional illness and have encouraged intelligent acceptance of the need for help with them. A most encouraging sign is the increasing, though still inadequate, fiscal attention being given to mental health problems by the government at local and state levels, and particularly at the federal level.

What therapies or treatments seem to be most suitable to young adults? What has been the nature of their success or failure?

Any of the "talking out" processes such as counseling or psychotherapy have proved most useful when undertaken by properly trained personnel. Drugs of the tranquilizer group especially have proved useful in allaying symptoms and facilitating psychotherapy.

Anxiety, psychoneuroses, and certain kinds of depression are commonly seen at this age. Schizophrenia, a serious illness, has its highest incidence in young adults. There are probably many causes of this disease. One etiological factor may consist in the conflict between inner needs and outer realities. Schizophrenia seems to arise when individuals whose emotional growth has been faulty or disrupted find themselves in life situations that are overwhelming. The realities of adult experience make heavy demands upon personality resources. Ordinarily, these realities provide adequate fulfillment of emotional needs. In persons who develop this illness, realities seem rather to interfere with adequate satisfaction of such needs at a critical level. In other words, there is increased sensitivity to emotional needs and instinctual impulses at a time when the pressures of social expectations, demands, and responsibilities are very intense. Such social pressures

may overwhelm the individual and destroy his usual defenses, so that he becomes unable to deal effectively with people and circumstances, or to achieve emotional satisfaction and fulfillment from them. Frightened, isolated, or frustrated, such an individual turns away from external and usual objects and sources of gratification to internal and special ones. It may be this characteristic juxtaposition of pressures for and against feeling and impulse expression, the conflict between internal need and external demands, that chiefly accounts for the high incidence of schizophrenia in young adults. Such illness is usually detected because of unusual behavior, sudden changes in behavior, or insidious deterioration of personality patterns over long periods of time. Hospitalization may be required, at least for the acute phase of the illness, and sometimes for long periods. Various treatments are used singly and in combination. Among these are psychotherapy and intensive drug therapy. Insulin coma treatment, electroconvulsive therapy, and certain kinds of surgery have special and limited indications, as do other pharmacological and physical therapies. Almost all of these are directed toward relief of symptoms rather than resolution of causes of illness. Recreational and occupational therapies are often used, especially in connection with inpatient programs. Present practice is to minimize rather than prolong the period of hospitalization, with outpatient treatment continuing for some time, and to emphasize psychotherapy over drug and physical therapies. Hospital facilities are seriously inadequate in number and many are woefully inadequate in the service they provide. Many general hospitals have set up psychiatric services, but there continues to be a critical need for many thousands of additional beds for emotionally disturbed people, especially young adults, in hospital situations where first-rate treatment, rather than custodial care, is emphasized.

How successful is the treatment of mental disorders?

It is very successful. In 1900 in one hospital, for example, the so-called cure rate for one form of schizophrenia was roughly 5 per cent against 95 per cent uncured. Now about 96 per cent are discharged as cured as against 4 per cent who remain ill. Even allowing for different interpretations of "cure" now as against 1900, this is a dramatic illustration of the fact that good treatment applied early is much more often successful than not. This is especially true in young adults who have the capacity to use treatment quite constructively.

Are the methods of treatment likely to undergo any change in the near future?

There is intense research going on in the whole area of mental illness. If there is as much progress in the twenty-five years ahead as has occurred in the past twenty-five years—and this does not seem to be unduly sanguine—there will surely be better, shorter, and less expensive treatment before long. We can look to chemotherapy for improvement, and also expect useful refinements in the understanding and application of psychotherapy.

Based on current studies, what might be predicted about the general mental health of young adults in the near future?

We may expect the same high incidence of illness and the widespread, and as individuals and institutions adopt better mental health effective treatment and prevention are developed, we should see some reduction in illnesses. As insight into emotions becomes more widespread, and as individuals and institutions adopt better mental health procedures in their day-to-day routine, one would also expect to see some reduction in the incidence and degree of anxiety, at least in its milder forms.

AGENCIES

Listed below is a directory of national, state, and local agencies to which individuals can turn for psychiatric help and mental health services. Individuals should look to their own community sources of help primarily; the national organizations can be of assistance mainly by providing literature or by referral to the proper local agency.

NATIONAL SOURCES:

National Institute of Mental Health
National Institutes of Health
Bethesda 14, Maryland

National Association for Mental
Health, Inc.
10 Columbus Circle
New York 19, New York

American Psychiatric Association
1700 18th Street, N.W.
Washington 9, D.C.

American Psychological Association
1333 16th Street, N.W.
Washington 6, D.C.

Family Service Association of America
44 East 23rd Street
New York 10, New York

Mental Health Materials Center
104 East 25th Street
New York 10, New York

National Association for Retarded
Children
386 Park Avenue South
New York 16, New York

National Organization for Mentally Ill
Children, Inc.
171 Madison Avenue
New York 16, New York

National Rehabilitation Association
1025 Vermont Avenue, N.W.
Washington, D.C.

American Public Welfare Association
1313 East 60th Street
Chicago 37, Illinois

National Epilepsy League, Inc.
208 N. Wells Street
Chicago 6, Illinois

Alcoholics Anonymous
General Service Office
P.O. Box 459
Grand Central Station
New York 17, New York

Goodwill Industries of America
1913 N Street, N.W.
Washington 6, D.C.

Child Welfare League of America
44 East 23rd Street
New York 10 New York

American National Red Cross
17th & D Streets, N.W.
Washington 6, D.C.

Community Chests of America, Inc.
155 East 44th Street
New York 17, New York

National Catholic Welfare Conference
1312 Massachusetts Avenue, N.W.
Washington 5, D.C.

Senior Citizens of America
1129 Vermont Avenue, N.W.
Washington 5, D.C.

National Jewish Welfare Board
145 East 32nd Street
New York 16, New York

National Council on Alcoholism
2 East 103rd Street
New York 29, New York

Licensed Beverage Industries, Inc.
Division of Education Studies
155 East 44th Street
New York 17, New York

National Association of Social Workers
95 Madison Avenue
New York 16, New York

Pan American Sanitary Bureau
Regional Office of World Health
Organization
1501 New Hampshire Avenue, N.W.
Washington 6, D.C.

National Council of Churches
475 Riverside Drive
New York 27, New York

Salvation Army
120 West 14th Street
New York 11, New York

Alcoholics Anonymous Family Groups
Council
40 East 40th Street
New York 17, New York

The American Speech and Hearing
Association
1001 Connecticut Avenue, N.W.
Washington 6, D.C.

American Association on Mental
Deficiency, Inc.
Mansfield Depot,
Connecticut

STATE SOURCES:

State Department of Public Health
Montgomery,
Alabama

Alabama Association for Mental
Health, Inc.
901 18th Street, South
Birmingham 5, Alabama

Alaska Department of Health and
Welfare
Juneau,
Alaska

Alaska Association for Mental Health
P.O. Box 777
Anchorage, Alaska

State Department of Health
Phoenix,
Arizona

Arizona Association for Mental
Health, Inc.
1515 East Osborne Road
Phoenix, Arizona

State Board of Health
Little Rock,
Arkansas

Arkansas Association for Mental Health
Tower Building
Room 1085
Little Rock, Arkansas

State Department of Mental Hygiene
Sacramento,
California

California Association for Mental
Health
1222 Noriega Street
San Francisco 22, California

State Department of Public Health
Denver,
Colorado

Colorado Association for Mental
Health, Inc.
1735 Gaylord Street
Denver 6, Colorado

State Department of Mental Health
Hartford,
Connecticut

The Connecticut Association for Mental
Health, Inc.
1303 Chapel Street
New Haven, Connecticut

State Board of Trustees
Delaware State Hospital
Farnhurst, Delaware

Mental Health Association of Delaware
1505 North Franklin Street
Wilmington, Delaware

**District of Columbia Department of
Public Health
Washington,
D.C.**

**District of Columbia Association for
Mental Health, Inc.
3000 Connecticut Avenue, N.W.
Washington 6, D.C.**

**State Board of Health
Jacksonville,
Florida**

**Florida Association for Mental Health
P.O. Box 5841
Jacksonville 7, Florida**

**Department of Public Health
Atlanta,
Georgia**

**The Georgia Association for Mental
Health, Inc.
209-212 Henry Grady Office Building
Atlanta 3, Georgia**

**State Department of Health
Honolulu, Oahu,
Hawaii**

**The Mental Health Association of
Hawaii
1407 Kalakaua Avenue
Honolulu 14, Hawaii**

**State Department of Health
Boise,
Idaho**

**Idaho Mental Health Association
#1 Route
Gooding, Idaho**

**State Department of Mental Health
Springfield,
Illinois**

**Illinois Association for Mental Health
709½ East Adams
Springfield, Illinois**

**State Department of Mental Health
Indianapolis,
Indiana**

**Indiana Association for Mental Health
615 North Alabama Street
Indianapolis, Indiana**

**The Psychopathic Hospital
Iowa City,
Iowa**

**The Iowa Association for Mental Health
306 Flynn Building
Des Moines, Iowa**

**State Board of Health
State Office Building
Topeka, Kansas**

**The Kansas Association for Mental
Health
214 West 6th Street
Topeka, Kansas**

**State Department of Mental Health
Louisville 2,
Kentucky**

**State Department of Hospitals
Baton Rouge,
Louisiana**

**Louisiana Association for Mental Health
1528 Jackson Avenue
New Orleans 13, Louisiana**

**State Department of Health and
Welfare
State House
Augusta, Maine**

**Maine Association for Mental Health
38 Oak Street
Orono, Maine**

**State Department of Health
Baltimore 18,
Maryland**

**Maryland Association for Mental
Health, Inc.
2100 North Charles Street
Baltimore 18, Maryland**

**State Department of Mental Health
Boston 8,
Massachusetts**

**The Massachusetts Association for
Mental Health, Inc.**
41 Mt. Vernon Street
Boston 8, Massachusetts

State Department of Mental Health
Lansing 13,
Michigan

Michigan Society for Mental Health
1528 Woodward Avenue
Detroit 26, Michigan

State Department of Public Welfare
St. Paul 1,
Minnesota

Minnesota Association for Mental Health
1645 Hennepin Avenue
Minneapolis 3, Minnesota

State Board of Health
Jackson,
Mississippi

**The Mississippi Association for Mental
Health**
State Office Building
Jackson, Mississippi

**Department of Public Health and
Welfare**
Jefferson City,
Missouri

Missouri Association for Mental Health
705 Jefferson Street
Jefferson City, Missouri

State Department of Mental Hygiene
Montana State Hospital
Warm Springs, Montana

Montana Association for Mental Health
315 Spruce Street
Anaconda, Montana

State Department of Health
Lincoln 9,
Nebraska

State Department of Health
Carson City,
Nevada

**Nevada Association for Mental
Health, Inc.**
1622 South Commerce Street
Las Vegas, Nevada

State Commission of Mental Health
Concord,
New Hampshire

**State Department of Institutions and
Agencies**
Trenton 25,
New Jersey

**The New Jersey Association for Mental
Health, Inc.**
60 South Fullerton Avenue
Montclair, New Jersey

State Department of Public Health
Santa Fe,
New Mexico

**New Mexico Association for Mental
Health**
2837 San Mateo Boulevard
Albuquerque, New Mexico

State Department of Mental Hygiene
State Office Building
Albany, New York

**The New York State Association for
Mental Health, Inc.**
105 East 22nd Street
New York 10, New York

State Board of Health
Raleigh,
North Carolina

**The North Carolina Mental Health
Association, Inc.**
P.O. Box 858
Greenville, North Carolina

State Department of Health
Capitol Building
Bismarck, North Dakota

**North Dakota Mental Health
Association**
P.O. Box 204
Jamestown, North Dakota

**Department of Mental Hygiene and
Correction
Columbus 16,
Ohio**

**The Mental Health Federation, Inc.
819-820 Union Central Building
Cincinnati 2, Ohio**

**State Department of Health
State Capitol Building
Oklahoma City 5, Oklahoma**

**The Oklahoma Association for Mental
Health, Inc.
309 Municipal Auditorium
Oklahoma City, Oklahoma**

**State Board of Health
Portland 1,
Oregon**

**Mental Health Association of Oregon
427 S.W. 11th Avenue
Portland 5, Oregon**

**State Department of Public Welfare
Harrisburg,
Pennsylvania**

**Pennsylvania Mental Health, Inc.
1601 Walnut Street
Philadelphia 3, Pennsylvania**

**State Department of Social Welfare
Providence,
Rhode Island**

**The Rhode Island Association for
Mental Health, Inc.
244 Thayer Street
Providence 6, Rhode Island**

**State Mental Health Commission
Columbia 2,
South Carolina**

**South Carolina Association for Mental
Health
2739 Devine Street
Columbia, South Carolina**

**State Department of Health
Pierre, South Dakota**

**South Dakota Mental Health
Association
P.O. Box 213
Huron, South Dakota**

**State Department of Mental Health
Nashville,
Tennessee**

**Tennessee Mental Health Association
218 Broadway National Bank Building
Broadway and Third
Nashville 3, Tennessee**

**State Department of Health
Austin,
Texas**

**The Texas Association for Mental
Health
2410 San Antonio Street
Austin 5, Texas**

**State Department of Health
Salt Lake City 13,
Utah**

**Utah Association for Mental Health
132 East Second South
Salt Lake City, Utah**

**Department of Health
Burlington,
Vermont**

**State Department of Mental Hygiene
and Hospitals
Richmond 14,
Virginia**

**The Virginia Association for Mental
Health, Inc.
312 West Grace Street
Richmond, Virginia**

**State Department of Health
Seattle 4,
Washington**

**Washington Association for Mental
Health
111 North Tacoma Avenue
Tacoma, Washington**

**State Department of Mental Health
Charleston 5,
West Virginia**

**The West Virginia Association for
Mental Health, Inc.
226½ Capitol Street
Charleston, West Virginia**

2084 Agencies

State Department of Public Welfare
State Capitol Building
Madison 2, Wisconsin

Wisconsin Association for Mental
Health

P.O. Box 1486
Madison, Wisconsin

State Department of Public Health
Senate Office Building
Cheyenne, Wyoming

Wyoming Association for Mental Health
10 West Winthrop
Newcastle, Wyoming

**REGIONAL OFFICES OF THE DE-
PARTMENT OF HEALTH, EDUCA-
TION, AND WELFARE (MENTAL
HEALTH STAFF)**

REGION I—(Connecticut, Massachusetts,
New Hampshire, Rhode Island,
Maine, Vermont)
Mental Health Division
Regional Office, Department of
Health, Education, and Welfare
120 Boylston Street
Boston 16, Massachusetts

REGION II—(Delaware, New Jersey, New
York, Pennsylvania)
Mental Health Division
Regional Office, Department of
Health, Education, and Welfare
Room 1200
42 Broadway
New York 4, New York

REGION III—(Kentucky, North Carolina,
Maryland, Puerto Rico, Virginia,
West Virginia, Virgin Islands,
District of Columbia)
Mental Health Division
Regional Office, Department of
Health, Education, and Welfare
700 East Jefferson Street
Charlottesville, Virginia

REGION IV—(Alabama, Georgia, Florida,
Tennessee, South Carolina, Missis-
sippi)
Mental Health Division

Regional Office, Department of
Health, Education, and Welfare
Room 440
50 Seventh Street, N.E.
Atlanta 23, Georgia

REGION V—(Illinois, Ohio, Michigan,
Indiana, Wisconsin)
Mental Health Division
Regional Office, Department of
Health, Education, and Welfare
Room 712
New Post Office Building
433 West Van Buren Street
Chicago 7, Illinois

REGION VI—(Iowa, North Dakota, South
Dakota, Kansas, Nebraska, Minne-
sota, Missouri)
Mental Health Division
Regional Office, Department of
Health, Education, and Welfare
Federal Office Building
911 Walnut Street
Kansas City 6, Missouri

REGION VII—(Arkansas, Texas, Okla-
homa, Louisiana, New Mexico)
Mental Health Division
Regional Office, Department of
Health, Education, and Welfare
1114 Commerce Street
Dallas 2, Texas

REGION VIII—(Colorado, Utah, Idaho,
Wyoming, Montana)
Mental Health Division
Regional Office, Department of
Health, Education, and Welfare
First National Bank Building
621 Seventeenth Street
Denver 2, Colorado

REGION IX—(Arizona, California, Ne-
vada, Oregon, Washington, Alaska,
Guam, Hawaii)
Mental Health Division
Regional Office, Department of
Health, Education, and Welfare
Room 441, Federal Office Building
Civic Center
San Francisco 2, California

LOCAL SOURCES:

Alcoholism clinics
American Red Cross local chapters
Associations for retarded children
Board of education (especially for
 psychological testing)
Catholic charity agencies
Child welfare services
Church pastors and clergymen
Community chest agencies
County or city health department,
 mental health division

Department of public welfare
Department of rehabilitation
General hospital psychiatric services
Jewish social service agencies
Marriage counseling agencies
Medical bureaus
Mental Health associations (voluntary
 agencies)
Mental Health clinics
Salvation Army
School counseling services
Suicide prevention centers (exist in a
 few major cities)

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GLOSSARY

ABERRATION: A temporary lapse from normal behavior; mental disorder, kind not specified.

ABNORMAL BEHAVIOR: Departure from the norm, however defined.

ABORTION: Expulsion of the human fetus prematurely, particularly at any time before it is viable.

ABREACTION: Emotional release or discharge resulting from recalling to awareness a painful experience which has been forgotten (repressed) because it was consciously intolerable. The therapeutic effect of abreaction is through discharge of the painful emotions, desensitization to them, and often increased insight.

ACAROPHOBIA: Morbid dread of skin parasites.

ACCIDENT: An event that was not intended or desired, especially one in which there is damage to persons or property.

ACCIDENT PRONE: Special susceptibility to accidents resulting from psychological or physical causes.

ACNE: A chronic inflammatory condition of the skin of the face, back, and chest, marked by many pimples; prevalent between puberty and the age of thirty.

ACROPHOBIA: Morbid fear of heights.

ACTING OUT: Expression of unconscious emotional conflicts or feelings of hostility or love in actions that the protagonist does not consciously know are related to such conflicts or feelings. May be harmful or, in controlled situations, therapeutic (e.g., children's play therapy).

ACTIVITY GROUP THERAPY: One type of *Group therapy* (q.v.), especially suitable for children.

ACUTE SITUATIONAL OR STRESS REACTION: A diagnostic term sometimes employed for certain acute emotional reactions incident to severe environmental stress as, for example, in military operations or civilian disasters.

ACYCLIC: Occurring independently of the menstrual cycle.

ADAPTATION: Change in structure or behavior that has survival value; generally, any beneficial change to meet environmental demand.

ADDICTION: Strong emotional and physiological dependence upon alcohol or a drug, which has progressed beyond voluntary control.

ADDICTION SYNDROME: See *Syndrome*.

ADJUNCTIVE THERAPY: An additional therapy, supplementing, but not an essential part of, the primary form of treatment. See *Therapy*.

ADJUSTMENT: A condition of harmonious relation to the environment wherein one is able to obtain satisfaction for most of one's needs.

ADOLESCENCE: The period from the beginning of puberty to the attainment of maturity; the transitional stage during which the youth is becoming an adult man or woman.

ADOPTION: The voluntary acceptance of a child of other parents as one's own; especially such acceptance as sanctioned by a legal process.

ADRENALIN: A hormone secreted by the central or medullary portion of the adrenal glands.

ADRENERGIC: Acting like *Adrenalin* (q.v.). Characterizing the hypothesized action of certain nerve fibers that produce at their terminals a substance called *Sympathin* (q.v.).

AEROPHAGIA: Excessive or morbid air swallowing.

AEROPHOBIA: Morbid dread of a current of air (draft).

AFFECT: A person's emotional feeling tone. Affect and emotion are commonly used interchangeably.

AFFECTIVE PSYCHOSIS: A psychotic reaction in which the predominant feature is a severe disorder of mood or emotional feelings. In general, equivalent to *Manic-depressive psychosis* (q.v.).

AGE SPACING: The spacing of children in a family for the optimum distribution of ages with respect to the mother's health and sibling compatibility.

AGENESIS: See *Aplasia*.

AGGRESSION: In psychiatry, forceful attacking action, physical, verbal, or symbolic.

CONSTRUCTIVE AGGRESSION: Self-protective and preservative; realistically evoked by threats from others; includes healthful self-assertiveness which is necessary to protect one's reasonable rights.

DESTRUCTIVE AGGRESSION: Not realistically essential for self-preservation or protection.

INWARD AGGRESSION: Directed toward the self.

AGING: The continuous process, beginning at conception and ending with death, wherein the structures and functions of an organism first become mature and then deteriorate.

AGITATED DEPRESSION: A psychotic depression accompanied by gross and continuous physical restlessness. See *Depression*.

AGITATION: State of chronic restlessness; a major psychomotor expression of emotional tension.

AGNOSIA: Inability to recognize and interpret the significance of sensory impressions due to organic brain disorders.

AGORAPHOBIA: Morbid fear of open spaces.

AKINESIC MUTISM: Mutism caused by loss or impairment of motor functioning. See *Mutism*.

ALCOHOLIC PSYCHOSES: A group of severe mental disorders, associated with brain damage or dysfunction, resulting from excessive use of alcohol. See also *Psychosis*.

ALCOHOLISM: The overuse of alcohol to the extent of habituation, dependence, or addiction. Alcoholism is medically significant when it impairs or threatens physical or mental health, or when it hampers personal relationships and individual effectiveness.

ALIENIST: Obsolescent legal term for a psychiatrist who testifies in court as to a person's sanity and mental competence.

ALZHEIMER'S DISEASE: A degenerative organic brain disease generally occurring in middle life. Similar to *Pick's disease* (q.v.).

AMAUROSIS: Loss of sight due to defect of the optic nerve; partial or absolute blindness from whatever cause.

AMAUROTIC IDIOCY: A form of congenital amaurosis, associated with severe mental defect and leading to early death.

AMBIVALENCE: The coexistence of two opposing drives, desires, feelings, or emotions toward the same person, object, or goal. These may be conscious or partly conscious, or one side of the feelings may be unconscious. Example: love and hate toward the same person.

AMEBIASIS: Infection with, or a disease caused by, amebas.

AMENORRHEA: Absence or suppression of menstruation from any cause other than pregnancy or menopause.

AMENTIA: Literally, absence of intellect as in severe congenital *Mental deficiency* (q.v.). The basis of amentia is usually organic and due to a developmental lack of adequate brain tissue. To be distinguished from *Dementia* (q.v.).

AMNESIA: Pathologic loss of memory; forgetting; a phenomenon in which an area of one's experience or recollections is split off and becomes consciously inaccessible. It may be of organic, emotional, or mixed origin, and sharply circumscribed in limits of time (i.e., *anterograde*, forward in time; or *retrograde*, backward in time).

AMPHETAMINE: A drug used in its sulfate form in narcolepsy, depressive psychopathic conditions, and for control of appetite in weight reduction.

AMPUTEE: A person who has had a limb or limbs amputated.

AMUCK: Characterized by a state of frenzy; an emotional outburst with homicidal tendencies.

AMYOTROPHIC LATERAL SCLEROSIS: A form of progressive muscular atrophy due to sclerosis of the lateral columns of the spinal cord.

ANACLITIC: Leaning on. In psychoanalysis, denotes dependence of the infant on the mother or mother substitute for his sense of well-being (e.g., gratification through nursing). Normal in childhood; pathologic in adult years.

- ANACLETIC DEPRESSION:** An acute and striking impairment of an infant's physical, social, and intellectual development which sometimes occurs following a sudden separation from the mothering person. See also *Depression*.
- ANAL CHARACTER:** A pattern of personality traits believed to be due to the habits, attitudes, and values formed when the child was learning control of defecation. Associated with the pleasure of *Anal expulsion* are the tendencies to conceit, suspicion, ambition; associated with the pleasure of *Anal retention* are the tendencies to meticulousness, parsimony or avarice, orderliness, and obstinacy.
- ANAL EROTISM:** Pleasurable part of the experience of anal function. In later life anal erotism usually appears in disguised and sublimated forms. See also *Erotic*; *Sublimation*.
- ANAL FIXATION:** Marked anal character resulting from the child's inability to reconcile anal pleasure with social demands.
- ANALGESIA:** A state in which the sense of pain is lulled or stopped.
- ANALYSAND:** A patient in psychoanalytic treatment.
- ANALYSIS:** A common synonym for *Psychoanalysis* (q.v.).
- ANALYTIC PSYCHOLOGY:** Metapsychologic system developed by the Swiss psychoanalyst, Carl Gustav Jung (1875–1961), which minimizes the influence of sexual factors in emotional disorders and stresses instead an inherited racial unconscious and a mystical religious factor.
- ANAMNESIS:** The developmental history of an individual and of his illness, especially a patient's recollections.
- ANDRIC:** Of, or belonging to, a male person.
- ANDROGEN:** A hormone that influences the development of maleness, either of structure or behavior.
- ANESTHESIA:** Loss of feeling or sensation, especially loss of tactile sensation, produced by disease, by hypnotism, or by administration of certain drugs, gases, etc.
- ANEURYSM:** A sac filled with blood formed by the dilatation of the walls of an artery or vein.

ANGER: An emotional reaction—aroused by being interfered with, injured, or threatened—that is characterized by certain distinctive facial grimaces, marked reactions of the autonomic nervous system, and by overt or concealed symbolic activities of attack or offense.

ANGINA PECTORIS: A heart disease marked by spasms of pain and suffocation in the chest.

ANIMA: A term in Jungian psychology denoting the unconscious or inner being as distinguished from the *Persona* (q.v.), the outward attitudes and character.

ANIMAL BEHAVIOR: The responses of subhuman animals to stimuli.

ANIMAL PSYCHOLOGY: The study of the behavior of animals, especially, the comparative study of different animal species. In many such studies the purpose is to derive general psychological principles.

ANOMIE: The state of being without organization or system, especially without natural law or uniformity.

ANOREXIA NERVOSA: A syndrome marked by severe and prolonged loss of appetite with marked weight loss and other symptoms resulting from emotional conflict.

ANOSMIA: Lack of sensitivity to smells.

ANOVULATION: Suspense or cessation of ovulation.

ANOVULATORY BLEEDING: Bleeding connected with anovulation.

ANOXIA: Deficiency in the supply of oxygen to the tissues.

ANTABUSE: A drug used in the treatment of chronic alcoholism. Also known as *Disulfiram* and *Tetraethylthiuram Disulfide*. Antabuse treatment is a form of deconditioning and is to be considered as adjunctive therapy.

ANTHROPOLOGY: The science of man; the comparative study of the chief divisions of man, including somatic characteristics, social habits and customs, linguistics, and prehistory.

ANTIBIOTIC THERAPY: Treatment based on the use of substances derived from a mold or bacteria which inhibits the growth of other microorganisms.

ANTICONVULSANT: An agent, as a drug, that tends to prevent or arrest convulsions.

ANTIDEPRESSANT: A drug used in the treatment of depression.

ANXIETY: Apprehension, tension, or uneasiness which stems from the anticipation of danger, the source of which is largely unknown or unrecognized. Anxiety is primarily of intrapsychic origin, in distinction to fear which is the emotional response to a consciously recognized and usually external threat or danger. Anxiety and fear are accompanied by similar physiologic changes. Anxiety may be regarded as pathologic when it is present to such extent as to interfere with effectiveness in living, the achievement of desired realistic goals or satisfactions, or reasonable emotional comfort.

ANXIETY HYSTERIA: Obsolescent term for a reaction characterized by the presence of phobias. See also *Hysteria*.

ANXIETY NEUROSIS: See under *Neuroses*.

APATHY: Lack of feeling or interest in situations that usually provoke such reactions.

APHASIA: Loss of ability to pronounce words, or to name common objects and indicate their use correctly. In *Motor aphasia* understanding remains but the memory traces necessary to produce a certain sound are lost. In *Sensory aphasia* ability to comprehend the meaning of words or phrases or the use of objects has been lost. Aphasias are due to organic brain disorder.

APHONIA: Loss of voice arising either from organic or from psychic causes, but not from brain lesion. The term is generally used today in connection with organic causes.

APHRODISIAC: Any agent that arouses sexual impulses.

APLASIA: Complete or partial failure of tissue to develop.

APOPLEXY: Sudden loss of consciousness and motor control caused by cerebral hemorrhage or thrombosis.

APPERCEPTION: Perception with understanding.

APPESTAT: The mechanism in the brain concerned with control of the amount of food intake.

APPLIED PSYCHOLOGY: The science or art of securing desired conduct in oneself or others. It deals with, or utilizes, all the physical, physiological, or social conditions as these relate to the person's effectiveness in the desired conduct.

APTITUDE: The capacity to acquire proficiency with a given amount of training, formal or informal.

APTITUDE TEST: A set of tasks so chosen and standardized that they yield an estimate of a person's aptitude on other tasks not necessarily having similarity to the test tasks.

AQUAPHOBIA: Morbid fear of water.

ARMAMENTARIUM: The equipment, especially of instruments or medicines, for use by a practitioner of medicine, dentistry, surgery, etc.

ARTERIOSCLEROSIS: Thickening of the walls of the arteries.

ARTHRITIS: Inflammation of a joint.

ART THERAPY: Use of art expression in the treatment of mental disorders.

ASSOCIATION: Relationship between ideas or emotions by contiguity, continuity, or by similarities.

ASTHENIA: Weakness.

ASTHMA: A disease marked by recurrent attacks of difficult respiration, due to some temporary change in the bronchial tubes or to a reflex spasm of the diaphragm.

ATARACTIC: Any agent or drug intended to induce ataraxy.

ATARAXY: Absence of anxiety; untroubled calmness.

ATAXIA: A loss of the power of muscular coordination.

ATOMICITY: Chemical valence, i.e., the power of an atom or group of atoms to combine with another atom or group of atoms; the degree of power that exists between certain bodies or substances, causing them to unite or produce a specific effect upon each other.

- ATROPHY:** A wasting away or decrease in size of cell, tissue, organ, or body part.
- AURA:** A premonitory subjective sensation. In epilepsy, an aura often precedes the convulsion.
- AUTHORITY:** A relation between two or more persons in which the commands, suggestions, or ideas of one of them influences the other(s).
- AUTISM (AUTISTIC THINKING):** A form of thinking that attempts to gratify unfulfilled desires without due regard for reality. Objective facts are distorted, obscured, or excluded in varying degree.
- AUTOEROTISM:** Securing or attempting to secure sensual gratification from oneself. A characteristic of an early stage of emotional development.
- AUTOMATISM:** Automatic and apparently undirected symbolic behavior which is not consciously controlled. Seen in *Schizophrenia*, *Dissociative reactions*, and *Epilepsy* (q.v.).
- AUTONOMIC NERVOUS SYSTEM:** That part of the nervous system ordinarily not subject to voluntary control. It operates outside of consciousness and controls basic life preserving functions such as the heart rate and breathing.
- BARBITURATE:** A salt of barbituric acid used in medicine as a hypnotic, sedative, and antispasmodic.
- BATTLE FATIGUE:** See *Combat fatigue*.
- BED-WETTING:** See *Enuresis*.
- BEHAVIORISM:** A body of psychologic theory developed by John B. Watson (1878–1958), concerned chiefly with objectively observable, tangible, and measurable data, rather than with subjective phenomena such as ideas and emotions.
- BELLADONNA:** A plant (deadly nightshade) with poisonous leaves and roots, used in medicine as a narcotic, antispasmodic, and respiratory and cardiac stimulant.
- BELL'S PALSY:** Peripheral facial paralysis.
- BENZEDRINE:** Proprietary name for *Amphetamine* (q.v.).

BERDACHE: One who adopts the dress and the manner of living of a person of the opposite sex.

BESTIALITY: Sexual relations between human and animal.

BIMODAL: Refers to a distribution that has two points at which the frequencies, or numbers of cases, are considerably greater than on either side of those points.

BIRTH CONTROL: See *Planned parenthood*.

BIRTHMARK: A congenital disfigurement or blemish; generally a pigmented place on the skin.

BIRTH ORDER: Relative order of birth of children in a single family.

BIRTH TRAUMA: According to Otto Rank (1844–1939), the psychic shock of birth.

BISEXUALITY: Possession of the bodily or psychological characteristics (generally only the secondary sex characteristics) of both sexes.

BLACKOUT: A term denoting the loss of consciousness. *Blackout threshold:* the level of oxygen deprivation at which such loss occurs.

BLOCKING: Difficulty in recollection, or interruption of a train of thought or speech, due to emotional factors usually unconscious.

BLOOD PLAQUE: A patch or small differentiated area on the skin or a mucous surface.

BLOOD PRESSURE: The pressure exerted by the blood against the walls of the arteries.

BODY IMAGE: The picture one has of one's own body at any moment, derived from internal sensations, postural changes, contact with outside objects and people, emotional experiences, and fantasies.

BODY LANGUAGE: A term used by psychiatrists to characterize the expression of feelings or thoughts by body movements.

BODY TYPE: A scheme for classification of individuals according to the pattern of anatomical characteristics, usually with the assumption that certain psychological characteristics are associated with each pattern.

BORBORYGMI: Rumbblings, gurglings, etc., in the stomach or intestines, produced by gas in the alimentary canal, and audible at a distance.

BORDERLINE PATIENT: (technical slang) A person near the dividing line between normal mental ability and mental deficiency.

BRAIN: That portion of the central nervous system enclosed within the skull. It includes the cerebrum, midbrain, cerebellum, pons, and medulla.

BRAIN ATROPHY: A wasting away of brain tissue.

BRAIN DAMAGE: Any structural injury to the brain, whether by surgery, accident, or disease; any brain injury before, during, or very soon after birth.

BRAIN DISORDER, ORGANIC: Any psychological syndrome caused by impairment of brain tissue function; corresponds in general to organic psychosis. See *Psychosis*.

BRAIN METABOLISM: See *Metabolism*.

BRAIN SYNDROME: A group of symptoms resulting from impaired brain function. May be acute (reversible) or chronic (irreversible).

BRAIN TRAUMA: See *Trauma*.

BRAIN TUMOR: See *Tumor*.

BRAINWASHING: A metaphorical term for the process of inducing a person to depart radically from his former behavior patterns and standards, and to adopt those imposed on him by his captors.

BRAIN WAVES: Spontaneous fluctuations in the electrical activity of the brain.

BREAKDOWN: A sudden onset of severe painful emotions, such as anxiety, tension, or feelings of guilt, which may be accompanied by physical symptoms, such as headache or dizziness, without a real physical basis.

BROMIDE: A drug (compound of bromine with another element) used in the treatment of epilepsy, and as a cardiac and cerebral depressant.

BULIMIA: Morbidly increased hunger.

CALLIGRAPHY: Fair or elegant writing or penmanship; handwriting in general.

CALORIE: A unit of heat expressing the heat-producing or energy-producing value of food.

CANNIBALISM: Act or practice of eating human flesh by mankind; hence, murderous cruelty, bloodthirsty barbarity.

CARBON DIOXIDE (CO₂) THERAPY: See under *Shock treatment*.

CAR SICKNESS: Nausea, dizziness, and sometimes vomiting, similar to sea and air sickness, sometimes caused by riding on a train or in an automobile.

CASTRATION: Loss of the genital organs. In psychiatry, usually the fantasied loss of the penis. Also used figuratively to denote state of impotence, powerlessness, helplessness, defeat, etc. See also *Castration complex* under *Complex*.

CASTRATION ANXIETY: Anxiety due to danger (usually fantasied) of loss of the genitals or injuries to them. See also *Castration complex* under *Complex*.

CATALEPSY: A condition in which the limbs or body remain passively in any position in which they are placed.

CATAPLEXY: Momentary loss of skeletal muscular tone with resulting weakness, induced by fear or shock; distinguished from *Catalepsy* (q.v.).

CATATONIA: A type of schizophrenia characterized by immobility with muscular rigidity or inflexibility. Alternating periods of physical hyperactivity and excitability may occur, and generally there is marked inaccessibility to ordinary methods of communication. See *Schizophrenia*.

CATHARSIS: (1) The healthful (therapeutic) release of ideas through a "talking out" of conscious material accompanied by the appropriate emotional reaction. (2) The release into awareness to some extent of repressed (i.e., "forgotten") material or experiences from the unconscious. *Abreaction* (q.v.) and catharsis are sometimes incorrectly used interchangeably.

CATHEXIS: Attachment of emotional feeling and significance to an idea or object, most commonly a person.

- CAUSALGIA:** Sensation of burning pain due to a wound or injury of a peripheral nerve.
- CELL:** The fundamental structural unit of organized living bodies.
- CENOTROPE:** A behavior pattern or habit shown by all members of a large group having the same biological equipment and the same sorts of experience.
- CENSOR:** In psychoanalytic theory, a part of the unconscious self (i.e., the superego and parts of the ego) which functions as a guardian to prevent the emergence of repressed material into consciousness.
- CENTRAL NERVOUS SYSTEM:** The brain and spinal cord.
- CEPHALALGIA:** Headache, or head pain.
- CEREA FLEXIBILITAS:** The "waxy flexibility" often present in catatonic schizophrenia in which the patient's arm or leg remains passively in the position in which it is placed.
- CEREBELLUM:** One of the major divisions of the brain.
- CEREBRAL ARTERIOSCLEROSIS:** Disease of the blood vessels in the brain.
- CEREBRAL DYSRHYTHMIA:** Abnormal rhythm in brain waves as revealed by *E.E.G.* (q.v.).
- CEREBRAL HEMORRHAGE:** Hemorrhage into the substance of the cerebrum.
- CEREBROSPINAL FLUID:** Lymph filling all the spaces in the cranial cavity and the spinal canal not occupied by solid tissues and blood vessels.
- CEREBRUM:** The main division of the brain in vertebrates, consisting of two hemispheres. It is probably of critical importance in mental activity or discriminatory behavior.
- CHANGE OF LIFE:** See *Menopause*.
- CHARACTER:** In psychiatry, the sum of the relatively fixed personality traits or habitual modes of response of an individual.
- CHARACTER ANALYSIS:** Analysis of the personality traits or defenses which characterize an individual.

CHARACTER DEFENSE: The concept of character or personality traits as serving an unconscious defensive purpose. See also *Character disorder*.

CHARACTER DISORDER: Unhealthy patterns of behavior and emotional response which are to varying degrees socially unacceptable or disapproved, accompanied by minimal outward evidence of anxiety or symptoms as ordinarily seen in the neuroses. The symptoms are *Ego-syntonic* (q.v.). Approximates concept of *Character neurosis*.

CHARACTER NEUROSIS: See *Character disorder*.

CHARACTER STRUCTURE: The integration of character traits. See *Character*. In psychoanalysis, the traits that result from the efforts of the superego to control the id. See *Id*; *Superego*.

CHEMOTHERAPY: Treatment of internal disease by means of chemical substances or drugs.

CHILD ANALYSIS: Treatment of a child according to psychoanalytic principles, utilizing play diagnosis and less formal techniques than in usual analysis.

CHILD DEVELOPMENT: An interdisciplinary study of the changes that take place in a child as he passes from birth to maturity, or (more commonly) from the end of infancy to the beginning of adolescence.

CHILD GUIDANCE: Study and treatment of the child, with emphasis on preventive or prophylactic measures designed to minimize the chances of mental and emotional disorders. Focus is mainly on the child's familial, educational, and social milieu.

CHILD GUIDANCE CLINIC: A clinic for professional guidance and help of children with major problems of adjustment. In general, help is given by a "team" consisting of two or more of the following: pediatrician, child psychiatrist, clinical child psychologist, and social worker.

CHILDHOOD NEUROSIS: See *Neuroses*.

CHILDHOOD PHOBIA: See *Phobia*.

CHILDHOOD PSYCHOSIS: See *Psychosis*.

- CHILD PSYCHIATRY:** The medical specialty that deals with the mental disorders of children.
- CHILD PSYCHOLOGY:** A subdivision of psychology that treats of the behavior or mental processes of children. It may deal with the normal or the abnormal.
- CHLORPROMAZINE:** An adrenolytic drug used to control nausea and vomiting from various causes, not including motion sickness; in certain psychiatric conditions it is used to alleviate manifestations of anxiety, tension, and agitation, and in lessening motor activity in both psychoneurotics and psychotics.
- CHOREA:** A neurological disorder characterized by jerky involuntary movements or spasms of short duration, involving a considerable set of muscles.
- CHROMOSOME:** One of the minute deeply staining bodies in the nucleus of a cell, believed to play an important or determinative part in heredity.
- CLAUSTROPHOBIA:** Morbid fear of closed spaces.
- CLIMACTERIC:** Menopausal period in women. Also refers to the corresponding age period in men.
- CLINICAL PSYCHOLOGY:** The branch of psychology that deals with the psychological knowledge and practice employed in helping a client who has some behavior or mental disorder. It includes training and practice in diagnosis, treatment, and prevention, as well as research.
- CLUTTERING:** Speech so rapid, under pressure of excitement, that enunciation is indistinct, words are run together, and syllables are slighted or dropped out.
- COENOTROPE:** See *Cenotrope*.
- COGNITIVE:** Refers to mental processes of comprehension, judgment, memory, and reasoning.
- COITUS:** The introduction of the male sex organ into the vaginal orifice of the female, generally with orgasm. See *Orgasm*.
- COLITIS:** Inflammation of the mucous membrane of the colon.

COLLECTIVE UNCONSCIOUS: In Jungian theory, a portion of the unconscious common to all mankind; also called racial unconscious. See *Unconscious*.

COMA: A state of suspension of all or nearly all behavior and most reflexes, with no response even to severely painful stimuli.

COMBAT FATIGUE: Disabling physical and emotional fatigue incident to military combat; also used as a term for combat neurosis.

COMMITMENT: Court procedure by which a person with a mental disorder is placed under restraint in an institution.

COMPENSATION: (1) A mental mechanism, operating unconsciously, by which the individual attempts to make up for (i.e., to compensate) real or fancied deficiencies. (2) A conscious process in which the individual strives to make up for real or imagined defects in such areas as physique, performance, skills, or psychologic attributes. The two types frequently merge.

COMPENSATION NEUROSIS: Certain neurotic reactions in which features of secondary gain (e.g., situational or financial) are prominent. See *Secondary gain*.

COMPLEX: A group of associated ideas which have a common strong emotional tone. These may be in part unconscious, and may significantly influence attitudes and associations. Three examples are:

OEDIPUS COMPLEX (Freud): Attachment of the child for the parent of the opposite sex, accompanied by envious and aggressive feelings toward the parent of the same sex. These feelings are largely repressed (i.e., made unconscious) because of the fear of displeasure or punishment by the parent of the same sex. In its original use, the term applied only to the male child.

CASTRATION COMPLEX: A group of emotionally invested ideas which are unconscious, actually or symbolically referring to fear of loss of the genital organs, usually as punishment for forbidden sexual desires. Includes the childhood fantasy that female genitals result from loss of a penis.

INFERIORITY COMPLEX (Adler): Feelings of inferiority stemming from real or imagined physical or social inadequacies which may cause anxiety or other adverse reactions. The individual may overcompensate by excessive ambition or by the development of special skills, often in the very field in which he was originally handicapped. See also *Over-compensation*.

COMPULSION: An insistent, repetitive, intrusive, and unwanted urge to perform an act which is contrary to the person's ordinary conscious wishes or standards. A defensive substitute for hidden and still more unacceptable ideas and wishes. Anxiety results from failure to perform the compulsive act.

COMPULSIVE PERSONALITY: A personality characterized by excessive adherence to rigid standards. Typically, the individual is rigid, overconscientious, overinhibited, lacks normal capacity for relaxation, and has repetitive patterns of behavior.

COMPULSIVE RITUAL: Series of acts repetitively carried out under compulsion. As with single compulsions, failure to carry out the ritual results in tension and anxiety.

CONCORDANCE: Agreement. In statistics, coefficient of *Concordance*: an estimate of general agreement among judges in ranking a group of individuals.

CONDENSATION: A psychologic process often present in dreams in which two or more concepts are fused so that a single symbol represents the multiple components.

CONDITIONED REFLEX: An induced reflex developed by repetitive experience in association with another stimulus. Example: A dog is repeatedly offered food while a bell is rung simultaneously. After a period of this conditioning, the ringing of the bell alone will bring on salivation and other responses originally present when food was presented.

CONDITIONED REFLEX PSYCHOLOGY: A school of psychology based on the theory of conditioned reflex, or conditioned response, i.e., the new or modified response that is elicited by a given stimulus after conditioning.

CONFABULATION: The more or less unconscious, defensive "filling in" of actual memory gaps by imaginary or fantastic experiences, often complex, that are recounted in a detailed and plausible way as though they were factual. Confabulation is seen principally in certain psychotic reactions, such as *Korsakoff's psychosis* (q.v.).

CONFLICT: The clash, conscious or unconscious, between two opposing emotional forces. If unconscious, an internal (instinctual) wish or striving is opposed by another internal and contradictory wish. For example, instinctual wish for gratification may conflict with the restrictions of conscience, or with external (social) requirements.

EXTRAPSYCHIC CONFLICT: Involves external factors; refers to conflicts between the self and the environment.

INTRAPSYCHIC CONFLICT: Internal conflict within the personality.

CONFORMITY: Correspondence to a recognized or required pattern or standard; a hypothetical trait or general tendency of an individual to accede to social pressure.

CONFUSION: Disturbed orientation in respect to time, place, or person; sometimes accompanied by disturbances of consciousness.

CONGENITAL: Present at birth.

CONSCIENCE: The morally self-critical part of oneself wherein have developed and reside standards of behavior, performance, and value judgments. Commonly equated with the conscious *Superego* (q.v.).

CONSCIOUSNESS: Awareness; in contrast to that aspect of mental life that is unconscious. See *Unconscious*.

CONSTELLATION: Any fairly inclusive and organized grouping of phenomena. A complex organization of ideas that is charged with emotion and tends toward certain kinds of action.

CONSTITUTION: A person's intrinsic physical and psychological endowment; sometimes used more narrowly to indicate the physical inheritance or potential from birth.

- CONSTITUTIONAL TYPES:** Constellations of morphological, physiological, and psychological traits as earlier proposed by various scholars. Galen, Kretschmer, and Sheldon proposed the following major types. *Galen*: Sanguine, melancholic, choleric, and phlegmatic types; *Kretschmer*: Pyknic (stocky), asthenic (slender), athletic, and dysplastic (disproportioned) types; *Sheldon*: Ectomorphic, mesomorphic, and endomorphic types, based on the relative preponderance of outer, middle, or inner layers of embryonic cellular tissue.
- CONTRACEPTION:** Voluntary limitation of offspring by artificially preventing the sperm cell from fertilizing the ovum.
- CONVALESCENT LEAVE:** Conditional release from a mental hospital for a home visit during recovery process.
- CONVERSION:** A mental mechanism, operating unconsciously, by which intrapsychic conflicts, which would otherwise give rise to anxiety, are instead given symbolic external expression. The repressed ideas or impulses, plus the psychologic defenses against them, are converted into a variety of somatic symptoms. Example: psychogenic paralysis of a limb which prevents its use for aggressive purposes.
- CONVERSION HYSTERIA:** See under *Neuroses*.
- CONVULSIVE DISORDERS:** Primarily grand mal, petit mal, Jacksonian, and psychomotor epilepsy. May occur in any organic cerebral disease. See *Epilepsy*.
- COPROPHAGIA:** Eating of filth or feces.
- COPROPHILIA:** Excessive or morbid interest in filth or feces or symbolic representations thereof.
- COPROPHOBIA:** The morbid fear of, or revulsion to, feces or dirt.
- CORTEX CEREBRI:** The surface layers of gray matter of the cerebral hemispheres.
- COUNSELING:** A relationship in which one person endeavors to help another to understand and to solve his adjustment problems. The term covers a wide area of procedures.
- COUNTERTRANSFERENCE:** The psychiatrist's conscious or unconscious emotional reaction to his patient. See also *Transference*.

CRANIUM: The part of the skull that contains the brain.

CREATIVITY: The power or quality of finding new solutions to a problem or new modes of artistic expression.

CRETINISM: Severe thyroid deficiency, usually accompanied by mental deficiency and bodily malformation.

CRIMINOLOGY: The systematic study of crime and criminals, with particular reference to the personality factors and social conditions leading toward, or away from, crime.

CROSS-SECTIONAL STUDY: A study of a large number of variables (persons, anatomical structures, psychological functions) as they all are at a single period of time.

CRYPTOMENORRHEA: The menstrual flow occurs but does not appear externally due to developmental defects.

CULTURE SHOCK: A term denoting the conflict arising in an individual confronted by alien elements in another culture.

CUNNILINGUS: Sexual activity in which the mouth and tongue are used to stimulate the female genitals.

CUSHING'S SYNDROME: A series of symptoms arising from disorders of the pituitary gland.

CUSTODIAL CARE: Close supervision or restraint, usually in a mental hospital, because of mental disorder or deficiency.

CYANOSIS: Blueness of the skin, generally caused by insufficient oxygen in the blood as a result of cardiac malformation.

CYBERNETICS: Science of control mechanisms. It covers the entire field of communication and control in machines and puts forth the hypothesis that there is some similarity between the human nervous system and electronic control devices.

CYCLOTHYMIC PERSONALITY: A personality characterized by alternating moods of elation and sadness, with mood swings out of proportion to apparent stimuli. The moods result from internal causes rather than from external events. In severe form, *Manic-depressive psychosis* (q.v.).

DAY-CARE CENTER: An establishment for the care of young children while the mothers are at work or are unable for other reasons to care for them during the day.

- DAYDREAM:** A reverie while awake. Usually the dreamer's unfulfilled wishes are imagined as fulfilled; the wishes are not disguised and fulfillment is imagined as direct, without repression.
- DEAF-MUTISM:** Lack of speech development resulting from congenital or early deafness.
- DEAFNESS:** Inability to hear, even with a hearing aid, well enough for the ordinary purposes of life. See *Hard-of-hearing*.
- DEATH INSTINCT:** In Freudian theory, the unconscious drive toward dissolution and death.
- DEATH WISH:** An aggressive instinct which leads to the death of the individual or of others when expressed in unmodified form.
- DECOMPENSATION:** Failure to compensate normally; activity intended to compensate but not succeeding.
- DEFENSE MECHANISM:** See *Mental mechanisms*.
- DEFORMITY:** Abnormal bodily formation, especially one that is visible and is considered ugly.
- DÉJÀ VU:** A subjective feeling that an experience which is occurring for the first time has happened before.
- DELIRIUM:** A disturbance in thinking and *Sensorium* (q.v.), with disorientation and confusion; illusions, delusions, or hallucinations may be present. Examples: delirium of fever, delirium tremens (alcoholic), bromide intoxication. Roughly equivalent to acute *Brain syndrome* (q.v.).
- DELIRIUM TREMENS:** An acute delirium precipitated by alcoholism, characterized by great anxiety, tremors, hallucinations, and delusions.
- DELUSION:** A false belief out of keeping with the individual's level of knowledge and his cultural group. The belief is maintained against logical argument and despite objective contradictory evidence. Common delusions include:
- DELUSIONS OF GRANDEUR:** Exaggerated ideas of one's importance or identity.
- DELUSIONS OF PERSECUTION:** Ideas that one has been singled out for persecution. See also *Paranoia*.

DELUSIONS OF REFERENCE: Incorrect assumption that certain casual or unrelated remarks or the behavior of others apply to oneself.

DEMENTIA: An old term denoting madness or insanity; now used entirely to denote organic loss of intellectual function.

DEMENTIA PRAECOX: Obsolescent descriptive term for *Schizophrenia* (q.v.).

DEMENTIA, SENILE: A chronic brain disorder caused by a generalized atrophy of the brain due to aging. See *Senile psychosis*.

DENIAL: A mental mechanism, operating unconsciously, and used to resolve emotional conflict and allay consequent anxiety by denying some of the important elements. The material denied may be a thought, wish, need, or external reality factors. What is consciously intolerable is simply disowned by the protectively automatic and unconscious denial of its existence.

DEPENDENCE: The degree to which a change in one area causes a change in another. *Dependency:* a lack of self-reliance; the tendency to seek the help of others in making decisions or in carrying out difficult actions.

DEPENDENCY NEEDS: Vital infantile needs for mothering, love, affection, shelter, protection, security, food, and warmth. These needs may continue beyond infancy in overt or hidden forms, or be increased in the adult as a regressive manifestation.

DEPERSONALIZATION: Feelings of unreality or strangeness concerning either the environment or the self.

DEPRESSION: Psychiatrically, a morbid sadness, dejection, or melancholy; to be differentiated from grief which is realistic and proportionate to what has been lost. A depression may vary in depth from neurosis to psychosis. The term *Neurotic depression* (see under *Neuroses*) encompasses various types of neurotic depressive reactions. The major psychotic depressions include *Agitated depression* (q.v.), *Involutional psychosis* (q.v.), and the depressed phase of *Manic-depressive psychosis* (q.v.).

DEPRIVATION, EMOTIONAL: Isolation of an infant from its mother to the extent that identification with the mother figure is not made, with resultant impaired personality development.

- DEPRIVATION, SENSORY:** Refers chiefly to experimental techniques which either reduce the intensity of stimuli reaching the subject or impose a structuring of stimuli. Similar in effect to *Brainwashing* (q.v.).
- DEPTH PSYCHOLOGY:** The psychology of unconscious mental processes. Also a system of psychology in which the study of such processes plays a major role, e.g., *Psychoanalysis* (q.v.).
- DEREISTIC:** Describes mental activity that is not in accordance with reality, logic, or experience. Similar to autistic. See *Autism*.
- DESCRIPTIVE PSYCHIATRY:** A system of psychiatry based upon observation and study of readily observable external factors; to be differentiated from dynamic psychiatry. Often used to refer to the systematized descriptions of mental illnesses formulated by Kraepelin. See also *Dynamic psychiatry*; *Psychiatry*.
- DEFERIORATION:** In mental illness, the progressive disintegration of intellectual and/or emotional functions in psychoses; may or may not be reversible.
- DETERMINISM:** A scientific doctrine common to psychiatry as well as other sciences. As applied to psychiatry, it postulates that nothing in the individual's emotional or mental life results from chance alone, but rather from specific causes or forces known or unknown.
- DEVELOPMENTAL PHASES OR STAGES:** Periods in an individual's life typically characterized by specific clusters of traits, such as *Oral stage*, *Puberty*, etc.
- DEVELOPMENTAL TASKS:** Levels of achievement or of development that, in a given society and at a given age, are considered appropriate or necessary for socially acceptable functioning.
- DEVIATE:** A person differing considerably from the average or standard; especially, one whose behavior or attitudes are not in accord with the prevailing patterns or the moral standards of the group.
- DEVIATION:** Departure from any point of reference, from the correct, the average, the standard, or the norm.
- DEXEDRINE:** Proprietary name for a drug used in *Narcolepsy* (q.v.), and in depressive psychopathic conditions.

DIAGNOSIS: Identification of disease or abnormality from symptoms presented, and from a study of its origin and course.

DIANETICS: An attempt, resting upon uncontrolled observation and extremely free speculation, to explain behavior in terms of the person's experience not only before birth but before conception.

DILANTIN: Proprietary name for an anticonvulsive compound used in the treatment of epileptic attacks.

DIPSOMANIA: Recurrent uncontrollable craving for alcoholic drink, usually at relatively long intervals; believed to be symptomatic of some more fundamental disorder.

DIRECTIVE THERAPY: A term used in psychotherapy, in distinction to nondirective therapy; denotes activity on the part of the therapist in guiding the patient.

DISCIPLINE: The control exercised by a superior over a subordinate; especially, the direct control of conduct. The habit patterns that cause a subordinate to be ready to act consistently in the manner prescribed by the superior.

DISORIENTATION: Loss of awareness of the position of the self in relation to space, time, or persons.

DISPLACEMENT: A mental mechanism, operating unconsciously, in which an emotion is transferred or "displaced" from its original object to a more acceptable substitute object.

DISSOCIATION: A psychologic separation or splitting off; an intrapsychic defensive process which operates automatically and unconsciously. Through its operation, emotional significance and affect are separated and detached from an idea, situation, or object. Dissociation may, unconsciously, defer or postpone experiencing the emotional impact as, for example, in selective amnesia. See *Mental mechanisms*.

DISSOCIATIVE REACTION: See under *Neuroses*.

DISTORTION: In Freudian theory, a prime mechanism which, in dreams, together with *Condensation* (q.v.), *Symbolization* (q.v.), and *Overdetermination* (q.v.), aids in the repression and disguise of unacceptable thoughts. See also *Mental mechanisms*.

PARATAXIC DISTORTION: Sullivan's term for certain distortions in judgment and perception, particularly in interpersonal relations, based upon the observer's need to perceive objects and relationships in accordance with a pattern set by earlier experience. Parataxic distortions develop as a defense against anxiety.

DISTRIBUTIVE ANALYSIS AND SYNTHESIS: The therapy used by the psychobiologic school of psychiatry developed by Adolf Meyer. Entails extensive guided and directed investigation and analysis of the patient's entire past experience, stressing his assets and liabilities and leading to a constructive synthesis. See *Psychobiology*.

DIZYGOTIC TWINS: Fraternal twins, i.e., twins that develop from two separately fertilized eggs.

DOMINANCE: In any psychological pattern, the relation of being more prominent or more important, of taking precedence, of being more pressing. Tendency to seek control over others.

DOMINANT AND RECESSIVE TRAITS: In genetics, the hereditary traits which produce and do not produce, respectively, observable effects in the offspring.

DOUBLE PERSONALITY: See *Personality, multiple*.

DREAM: A psychic phenomenon occurring during sleep in which thoughts, images, and so on, are present to the dreamer, usually with a sense of reality.

DREAM ANALYSIS: The fundamental technique of psychoanalysis, wherein the client relates a dream and free-associates about its elements. See *Free association*.

DRIVE: In psychiatry, a term for motivation; a basic urge.

DRUG ADDICTION: Continued reliance upon the effects of a narcotic drug, with the effect that progressively stronger doses are required to obtain effects, and that there is both psychological and physiological distress when the drug is withdrawn. See *Narcotic*.

DRUG THERAPY: Treatment by recognized medicines or preparations.

DUALISM: Any of several philosophical theories that admit of two fundamentally different sorts of principles or entities in the universe, usually conceived as mental and material; in psychology, a point of view that accepts a distinction of some sort between mental and physical phenomena.

DURHAM DECISION: Refers to a decision by the U.S. Court of Appeals for the District of Columbia (1954) in which the Court stated that the M'Naghten Rule and the Irresistible Impulse Test were not consonant with the realities of mental life as reflected in modern psychiatry, and held that "an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect." (Durham *vs.* U.S., 214 F 2d 862.) Under the Durham test, a psychiatrist may give any relevant testimony about the mental illness at issue, whereas, before, his testimony had been confined to a determination of whether the accused could distinguish "right or wrong" or acted under an "irresistible impulse." The Durham test proceeds on the assumption that when the criminal act of the accused is the product of his mental illness, the suggested conclusion is that the accused should be hospitalized for treatment and possible rehabilitation, a premise more in harmony with modern psychiatric thought than the earlier tests of legal responsibility. See also *M'Naghten Rule*; *Irresistible impulse test*.

DWARFISM: Extreme deficiency in stature.

DYNAMIC PSYCHIATRY: As distinguished from descriptive psychiatry, refers to the study of emotional processes, their origins, and the mental mechanisms. Dynamic psychiatry implies the study of the active, energy-laden, and changing factors in human behavior, as opposed to the older, more static and descriptive study of clinical patterns, symptoms, and classification. As an adjective, *dynamic* indicates energy potential, constant change, mutual interaction, shifting emphasis, and development. Dynamic principles are those which are forceful, driving, and compelling. They convey the concepts of change, of evolution, and of progression or regression. See also *Descriptive psychiatry*; *Psychiatry*.

DYNAMICS: The determination of how an emotional or a behavior pattern develops; the mechanisms of the development of emotional reactions, especially intrapsychic defense mechanisms.

DYNAMISM: See *Mental mechanisms*.

DYSARTHRIA: Impaired, difficult speech, usually due to organic disorders of the nervous system. Sometimes applies to emotional speech difficulties, such as stammering and stuttering.

DYSMENORRHEA: Difficult and painful menstruation.

DYSPAREUNIA: Pain experienced by the female in sexual intercourse.

DYSPHAGIA: Difficult or painful swallowing.

DYSPLASIA: Abnormal growth or development.

ECHINOCOCCUS: A genus of tapeworms.

ECHOLALIA: The automatic repetition by some psychotic patients of phrases or words said in their presence. Most frequent in certain schizophrenic disorders.

ECHOPRAXIA: Automatic repetition by some psychotic patients of movements made in their presence.

ECOLOGY, HUMAN: The branch of science dealing with the interaction of the human organism with its total environment and of human personality as derived from such interaction.

E.C.T.: Electroconvulsive therapy. See *Electroshock therapy*.

ECTODERM: The outermost of the three cell layers in the embryo.

ECTOMORPHIC: Pertaining to bodily structures developed from the embryonic *Ectoderm* (q.v.).

Ectomorphic Type: According to a scheme, proposed by W. H. Sheldon, of classifying body types with regard to the relative dominance of components belonging to one of the three embryonic developmental systems, the ectomorphic type is relatively thin, with a large skin surface in comparison with weight. For the other two types, see *Endomorphic*; *Mesomorphic*.

EDEMA: Excessive accumulation of fluid in the tissue spaces.

E.E.G.: Electroencephalogram. A recording of minute electrical impulses arising from the activity of cells in the cerebral cortex of the brain.

EGO: Refers to the conscious self, the "I." In Freudian theory, the central part of the personality that deals with reality and is influenced by social forces. The ego modifies behavior by largely unconscious compromise between the primitive instinctual drives (the id) and the conscience (the superego). The ego serves as the mediator and is also the battleground between unconscious impulses and personal plus social standards.

EGO ANALYSIS: The intensive psychoanalytic study and analysis of the ways in which the ego resolves or attempts to deal with intrapsychic conflicts, especially in relation to the development of mental mechanisms and the maturation of capacity for rational thought and action.

EGO-DYSTONIC: At variance with, or repugnant to, the ego.

EGO IDEALS: That part of the personality which comprises the aims and goals of the self; usually refers to the conscious or unconscious emulation of significant persons with whom it has identified.

EGO IDENTITY: The sense of identity which gives the individual the ability to experience his self as something that has continuity, and to act accordingly.

EGO INSTINCTS: A hypothetical concept in which certain human drives, commonly power, prestige, and acquisition, are regarded by some as instinctual.

EGOMANIA: Exaggerated self-centeredness.

EGO-SYNTONIC: Acceptable to, or consonant with, the aims of the *Ego* (q.v.).

EGOTROPIC: Self-centered; introspective.

EIDETIC IMAGE: Unusually vivid and apparently exact mental image; may be a memory, fantasy, or dream.

ELABORATION: An unconscious psychologic process of expansion and elaboration of detail, especially with reference to a symbol or representation in a dream.

ELECTRA COMPLEX: A term no longer in general use. Analogous to *Oedipus complex* (q.v.), under *Complex*.

ELECTROENCEPHALOGRAM: See *E.E.G.*

ELECTROSHOCK THERAPY (E.S.T.): The therapeutic administration of carefully regulated electrical impulses to the brain. Coma and/or convulsions are produced. See also *Shock treatment*.

ELECTROSTIMULATION: See under *Shock treatment*.

ELECTROTHERAPY: The use of repeated, brief, nonconvulsive electric impulses as part of the treatment for mental or bodily ills.

EMOTION: A subjective feeling (of which one may or may not be specifically aware), such as fear, anger, grief, joy, or love.

EMOTIONAL CRISIS: A sudden change in an individual caused by emotions.

EMOTIONAL HEALTH: A state of being which is relative rather than absolute, in which a person has effected a reasonably satisfactory integration of his instinctual drives. His integration is acceptable to himself and to his social milieu as reflected in the satisfactory nature of his interpersonal relationships, his level of satisfaction in living, his actual achievement, his flexibility, and the level of emotional maturity he has attained.

EMOTIONALLY DISTURBED: A term denoting mental illness arising from emotions.

EMPATHY: An objective and insightful awareness of the feelings, emotions, and behavior of another person, and their meaning and significance. To be distinguished from sympathy, which is nonobjective and usually noncritically emotional.

ENCEPHALITIS: Any acute inflammation of the brain or its membranous coverings; specifically, an infectious disease of the brain with symptoms of drowsiness and apathy. Serious neurological and personality changes persist after recovery from the acute stage.

ENCOPRESIS: Involuntary defecation not due to local organic defect or illness.

ENDOCRINE DISORDER: Disturbance arising from malfunctioning of a gland of internal secretion.

ENDODERM: The innermost of the three cell layers in the embryo that develops into the digestive tract and most of the viscera.

ENDOMORPHIC: Pertaining to bodily structures developed from the embryonic *Endoderm* (q.v.).

Endomorphic Type: Relatively heavy, with highly developed viscera and relatively weak muscular and bony structure. See *Ectomorphic*; *Mesomorphic*.

ENERGIZER: That which activates the body or mind.

ENGRAM: A hypothesized, permanently altered state of a living tissue resulting from temporary excitation. The term is somewhat loosely used in psychiatry to refer to persisting psychical traces (usually unconscious) of any experience.

ENURESIS: Bed-wetting.

ENVIRONMENT: The sum of the external conditions and factors potentially capable of influencing an organism. See *Milieu therapy*.

ENZYME: One of several organic compounds, of special importance in digestion, that is capable of producing other compounds by catalytic action.

EONISM: See *Transvestism*.

EPIDEMIOLOGY: The branch of medical science dealing with epidemics.

EPILEPSY: A disorder characterized by periodic motor or sensory seizures or their equivalents, and sometimes accompanied by a loss of consciousness, or by certain equivalent manifestations. May be *idiopathic* (no known organic cause) or *symptomatic* (due to organic lesions).

EPILEPTIC EQUIVALENT: An epileptic manifestation or symptom other than a convulsive motor attack.

JACKSONIAN EPILEPSY: Recurrent episodes of localized convulsive seizures or spasms limited to a part or region of the body, without loss of consciousness.

MAJOR EPILEPSY (GRAND MAL): Characterized by gross convulsive seizures, with loss of consciousness.

MINOR EPILEPSY (PETIT MAL): Minor nonconvulsive epileptic seizures or equivalents; may be limited to only momentary lapses of consciousness.

- EQUANIL:** Proprietary name for *Meprobamate* (q.v.), used to relieve anxiety and tension.
- EROGENOUS:** Giving rise to sexual or erotic behavior or feeling.
- EROTIC:** Consciously or unconsciously invested with sexual feeling; sensually related.
- EROTOGENIC ZONE:** An area of the body particularly susceptible to erotic arousal when stimulated, and specially the oral, anal, and genital areas. Sometimes called *Erogenous zone*.
- E.S.P.:** See *Extrasensory perception*.
- E.S.T.:** See *Electroshock therapy*.
- ETHOLOGY:** The science of ethics; the empirical study of human character; the study of manners, customs, and mores; the study of comparative behavior or of the ecology of behavior. See *Ecology*.
- EUPHORIA:** An exaggerated feeling of physical and emotional well-being not consonant with apparent stimuli or events; usually of psychologic origin, but also seen in organic brain disease and toxic states.
- EVOCATIVE THERAPY:** A term used in psychotherapy to denote emphasis on evoking responses from the patient rather than directing the patient. See *Directive therapy*.
- EXAMINATION FEAR:** A neurotic fear connected with academic examinations.
- EXCEPTIONAL CHILD:** A child who deviates considerably from the average in physique, sensory acuity, intelligence, social conformity, or emotional development. The term is used for both extremes (i.e., gifted and feeble-minded), but the current tendency is to restrict it to the handicapped.
- EXHIBITIONISM:** Commonly, "showing off." Psychiatrically, body exposure, usually of the male genitals to females. Sexual stimulation or gratification usually accompanies the act.
- EXORCISM:** Act or process of expelling or driving off an evil spirit by adjuration, especially by use of a holy name; also a formula used in such act or process.

- EXTRASENSORY PERCEPTION:** That which is apparently known or perceived without recourse to the conventional use of any of the five physical senses.
- EXTROVERSION:** A state in which attention and energies are largely directed outward from the self, as opposed to interest primarily directed toward the self as in *Introversion* (q.v.).
- FANTASY:** An imaginary sequence of events or mental images. Normal in children, but in adults fantasies may represent an attempt to avoid emotional conflicts by serving as substitute satisfactions.
- FATHER IMAGE:** See *Imago*.
- FATHER SURROGATE:** One who is reacted to as if he stood in place of a father.
- FEAR:** Emotional response to consciously recognized and external sources of danger, to be distinguished from anxiety. See *Anxiety*; *Phobia*.
- FEEBLEMINDEDNESS:** Intelligence and mental capacity considerably lower than normal (100 I.Q.). Usually refers to cases of moron level (50 to 69 I.Q.). See *Mental deficiency*.
- FEEDBACK:** In a machine, the automatic signaling of the degree of performance or nonperformance of an operation; in an organism, the sensory report of the somatic result of a behavior; in social psychology, a direct perceptual report of the result of one's behavior upon other persons.
- FELLATIO:** Sexual stimulation of the penis by oral contact.
- FEMININITY:** The usual characteristics, taken collectively, of women.
- FERTILITY:** The having of many offspring; figuratively, the having of many ideas. Distinguished from fecundity, the capacity to have offspring.
- FETISH:** An object symbolically endowed with special power or meaning; often "magical." May have conscious or unconscious sexual meaning.
- FETISHISM:** Process of attachment of special meaning to an inanimate object (or fetish) which serves, usually unconsciously, as a substitute for the original object or person. The substitute object is often a neurotic source of sexual stimulation or gratification.

- FIXATION:** The arrest of psychosexual maturation. Depending on degree it may be either normal or pathologic. See *Psychosexual development*.
- FLAGELLANTISM:** A masochistic or sadistic act in which one or both participants derive stimulation, usually erotic, from whipping or being whipped.
- FLEXIBILITAS CEREAE:** See *Cereae flexibilitas*.
- FLIGHT OF IDEAS:** Verbal skipping from one idea to another before the last one has been concluded; the ideas appear to be continuous, but are fragmentary and determined by chance associations. Most commonly seen in the manic phase of *Manic-depressive psychosis* (q.v.).
- FOLIE À DEUX:** A psychotic reaction in which two closely related persons, usually familial, mutually share the same delusions.
- FORECONSCIOUS:** Preconscious; material not ordinarily in consciousness, but subject to voluntary recall.
- FORENSIC PSYCHIATRY:** Treats of legal questions in relation to disordered behavior, particularly the questions of mental responsibility, committability, and the like.
- FOREPLEASURE:** Sexual play preceding intercourse.
- FORMICATION:** In psychiatry, the hallucination that insects are crawling on the body.
- FOSTER HOME PLACEMENT:** Placement of an individual (usually a child) for care and sustenance in the home of persons not related by blood or marriage.
- FREE ASSOCIATION:** In psychoanalytic therapy, unselected verbalization by the patient of whatever comes to mind.
- FREE-FLOATING ANXIETY:** Pervasive anxiety which the patient cannot explain to his own satisfaction. See *Anxiety*.
- FRIEDREICH'S ATAXIA:** See *Ataxia*.
- FRIGIDITY:** In psychiatry, disinterest in sex approaching aversion; usually applied to the female who has inadequate or no pleasurable sensations in intercourse.

- FROEHLICH'S SYNDROME:** A group of symptoms associated with insufficient pituitary activity: delay in skeletal development, obesity, infantilism, or childishness of body appearance.
- FRONTAL LOBOTOMY:** Brain surgery involving the frontal lobe, i.e., the upper or forward half of the cerebral hemisphere. See *Psychosurgery*.
- FROTTAGE:** A form of sexual perversion in which orgasm is induced by rubbing against the clothing of a person of the opposite sex.
- FRUSTRATION:** The blocking of, or interference with, an ongoing goal-directed activity; the state resulting from being blocked, thwarted, disappointed, or defeated. In psychoanalysis, generally refers to the denial of gratification by reality.
- FUGUE:** A major state of personality dissociation characterized by amnesia and actual physical flight from the immediate environment.
- FUNCTIONAL ILLNESS:** An illness of emotional origin in which organic or structural changes are either absent or are developed secondarily to prolonged emotional stress.
- GALACTOSEMIA:** A metabolic disorder in which there is an increased galactose (white crystalline substance resembling glucose) level in the blood.
- GANGLION:** A group of nerve cells or cell bodies lying outside the brain and cord, and forming a sort of nerve center; a cystic tumor-like lesion occurring on a joint or tendon sheath.
- GENE:** An inferred submicroscopic structure in the *Chromosome* (q.v.) which is the physical unit of heredity.
- GENERAL PARESIS:** A psychosis associated with organic disease of the central nervous system resulting from chronic syphilitic infection.
- GENIUS:** A generic term denoting markedly superior intellectual, emotional, or creative ability; a person exhibiting such ability.
- GERIATRICS:** The science that deals with the problems and diseases of the aging and the old.
- GESTALT PSYCHOLOGY:** A German school of psychology which places emphasis on a total perceptual configuration and the interrelations of its component parts.

- GIFTED CHILD:** A child whose intelligence is in the upper 2 per cent of the total population of his age; a child having outstanding ability in any respect.
- GIGANTISM:** Abnormal increase in stature due to the overfunctioning of the pituitary gland. (*Giantism*: nontechnical synonym.)
- GLAND:** An organ for secreting or producing a substance to be used in, or excreted from, the body, or for producing cells.
- GLOBUS HYSTERICUS:** A hysterical symptom in which there is a disturbing sensation of a lump in the throat.
- GOITER:** A chronic enlargement of the thyroid gland not due to a neoplasm.
- GONAD:** A sex gland; the generic term for testis and ovary.
- GRANDIOSE:** In psychiatry, refers to delusions of great wealth, power, or fame.
- GRAND MAL:** See *Epilepsy*.
- GRAPHODYNE:** A mechanism that transmits handwriting pressure to a recording device.
- GRAPHOLOGY:** Any investigation of handwriting; the analysis of handwriting characteristics for personal identification, for indications of specific psychological states at the time of writing, or for personality analysis.
- GRAPHOMOTOR:** Relating to, or affecting, movements executed in writing.
- GRAPHOMOTOR PROJECTIVE TECHNIQUE:** A diagnostic procedure in which the subject moves his pencil freely over a sheet of paper while blindfolded. The tester then endeavors to interpret the drawings.
- GRIEF:** Normal, appropriate emotional response to an external and consciously recognized loss; self-limiting, and gradually subsiding within a reasonable time. To be distinguished from depression. See also *Depression*.
- GROUP DYNAMICS:** The cause-effect changes that take place within a social group; the way groups form and function.
- GROUP PSYCHOTHERAPY:** Alternative term for *Group therapy*.

GROUP THERAPY: Psychotherapy carried out with a group of patients.

GUIDANCE: Helping a person to find and select the opportunities and activities that will yield maximum satisfaction and profit, especially in school (educational guidance) and in his lifework (vocational guidance). A form of supportive psychotherapy.

GUILT, SENSE OF: Realization that one has violated ethical, moral, or religious principles, together with a feeling of lessened personal worth.

GYNIC: Of, or belonging to, a female person.

HABEAS CORPUS: Legal proceeding for inquiring into the lawfulness of a person's restraint in another's custody.

HALFWAY HOUSE: A term denoting intermediate day care for mental patients prior to discharge.

HALLUCINATION: A false sensory perception in the absence of an actual external stimulus. May be of emotional or chemical (drugs, alcohol, etc.) origin, and may occur in any of the five senses.

HALLUCINOGEN: A chemical agent that produces hallucinations.

HALLUCINOSIS: A state in which the patient is actively hallucinating. Example: alcoholic hallucinosis.

HAPTICS: The investigation of cutaneous sense data, of touch in its widest sense.

HARD-OF-HEARING: Having a hearing deficiency but, in distinction to *Deafness* (q.v.), able to hear with the use of a hearing aid.

HEBEPHRENIA: See *Schizophrenia*.

HEDONISM: The psychological doctrine that every act is motivated by the desire for pleasure or the aversion from unpleasure. In ethics, the doctrine that it is a duty to seek pleasure and to avoid unpleasure or pain. In psychiatry, the seeking of certain goals because they offer some type of gratification.

HEREDITY: The totality of influences, biologically transmitted from parents, that determines the ways in which an individual will make use of his environment; the transmission from parents to offspring of that which tends toward the manifestation of certain characteristics of the latter.

HERMAPHRODITE: An individual who possesses both male and female sexual organs to some degree; almost invariably one sex is predominant.

HEROIN: A white crystalline morphine derivative which is one of the more widely used of the habit-forming narcotics.

HETEROSEXUAL: Sexual attraction or relationship between individuals of opposite sexes.

HOLISM: The doctrine that a human being has properties which pertain to the whole rather than to its constituent parts, and that the dynamics of the person as a whole cannot be explained as resulting from independent elements.

HOMEOSTASIS: The maintenance of self-regulating metabolic or psychologic processes which are optimal for individual and racial survival.

HOMESICKNESS: A yearning for the familiar home and persons which is so strong that it disrupts behavior and sometimes gives rise to somatic symptoms.

HOMOSEXUAL PANIC: An acute and severe attack of anxiety based upon unconscious conflicts involving homosexuality.

HOMOSEXUALITY: Sexual attraction or relationship between members of the same sex.

ACTIVE HOMOSEXUALITY: Homosexuality marked by overt activity.

LATENT HOMOSEXUALITY: Unconscious homosexual desires or conscious desires, consistently denied expression.

HORMONE: A chemical substance produced by one organ and carried by the blood or lymph to another, where it produces a characteristic physiological effect.

HOSTILITY: Tendency to feel enmity and more or less enduring anger toward, and to seek to inflict harm upon, a person or a group.

HUNTINGTON'S CHOREA: Hereditary, chronic, progressive chorea with mental deterioration. See *Chorea*.

HYDROCEPHALUS (HYDROCEPHALY): A condition of excessive amount and pressure of cerebrospinal fluid within the skull, characterized by marked enlargement of the head and an underdeveloped or atrophied brain.

HYDROTHERAPY: Treatment by means of hot or cold water, externally applied in bottles, packs, or baths.

HYPER: A prefix denoting abnormal excess in extent or degree.

HYPERMNESIA: Unusual memory ability; exaggerated activity of memory.

HYPERPLASIA: Excessive increase in the number of cells in a tissue or organ.

HYPERTENSION: Any high tension in a tissue; more specifically, high blood pressure.

HYPERTHYROIDISM: A condition in which there is excessive secretion by the thyroid gland; its most direct psychological correlate is great excitability and restlessness.

HYPERTONIA: Extreme tension of the muscles; spasticity or rigidity.

HYPERTONIC: Characterized by excessive tension of a muscle.

HYPNAGOGIC: Intermediate state between waking and sleeping. Also spelled *Hypnagogic*.

HYPNOGENIC: Relating to the induction of sleep or the hypnotic state.

HYPNOPOMPIC: Relating to the semiconscious state between the stages of sleep and awakening; applied to visions or dreams that persist prior to complete awakening.

HYPNOSIS: An altered state of conscious awareness induced in a suggestible subject. Under hypnosis a person manifests increased receptivity to suggestion and direction.

HYPO (HYP): A prefix denoting under, below, less than the normal.

HYPOCHONDRIA: See under *Neuroses*.

HYPOGLYCEMIA: A deficiency of sugar in the blood.

HYPOMANIA: Mild mania. See *Mania*.

HYPOTENSION: Subnormally low blood pressure.

HYPOTHALAMUS: A group of nuclei at the base of the brain, involved in many visceral regulative processes.

HYPOTHYROID: Deficient in thyroid secretion or activity.

HYPOTONIA: Subnormal tension of the muscles; flaccidity.

HYPOTONIC: Characteristic of a muscle lacking tone or tension.

HYSTERECTOMY: Removal of the uterus.

HYSTERIA: An illness resulting from emotional conflict and generally characterized by immaturity, impulsiveness, attention-seeking, dependency, and the use of the mental mechanisms of conversion and dissociation. Classically manifested by dramatic physical symptoms involving the voluntary muscles or the organs of special senses. See also *Conversion*; *Dissociation*; *Neuroses*.

HYSTERICAL PERSONALITY: A personality type characterized by shifting emotional feelings, susceptibility to suggestion, impulsive behavior, attention-seeking, immaturity, and self-absorption; not necessarily disabling.

HYSTERIC: Lay term for uncontrollable emotional outbursts.

IATROGENIC ILLNESS: An emotional illness unwittingly precipitated by the physician's attitude, examination, or comments.

ID: In Freudian theory, that part of the personality structure which harbors the unconscious instinctive desires and strivings of the individual.

IDEALIZATION: A mental mechanism, operating unconsciously, in which there is overestimation of some admired aspect or attribute of another person.

IDEAS OF REFERENCE: Incorrect interpretation of casual incidents and external events as having direct reference to oneself. May reach sufficient intensity to constitute delusions.

IDÉE FIXE: Fixed idea; has been loosely used to describe a compulsive drive, an obsessive idea, or a *Delusion* (q.v.).

IDENTIFICATION: A mental mechanism, operating unconsciously, by which an individual endeavors to pattern himself after another. Identification plays a major role in the development of one's personality and specifically of one's superego (conscience). When done consciously, this is called imitation.

- IDENTITY:** Sameness of essential character despite superficial differences. *Personal identity:* the unity of personality over a period of time.
- IDEOGRAM:** An element in a system of writing wherein an object or an idea is directly represented by a single symbol.
- IDIOPATHIC:** Of a diseased condition or symptom whose origin is within the organ involved and not the result of something external to the organ; of a disease that is primary, i.e., does not result from another disease.
- IDIOT:** A person with the lowest order of intellectual potential. The I.Q. is below 20 as compared with a normal of 100. See *Mental deficiency*.
- ILLUSION:** The misinterpretation of a real, external sensory experience.
- IMAGO:** An unconscious mental image, usually idealized, of an important person in the early history of the individual.
- IMBECILE:** A person with a low order of intellectual potential, intermediate between idiot and moron. The I.Q. is 20-49 as compared with a normal of 100. See *Mental deficiency*.
- IMIPRAMINE:** A drug used as an antidepressant.
- IMPLEMENTATION:** The carrying out or performing of a task or assignment.
- IMPOTENCE:** Usually refers to inability of the male to perform the sexual act, generally for psychologic reasons; more broadly used to indicate lack of sexual vigor, powerlessness.
- IMPULSE:** A psychic striving; usually refers to an instinctive urge.
- IMPULSION:** A recurrent compulsive urge leading to the commission of unlawful or socially disapproved acts. Examples: *Kleptomania*; *Pyromania* (q.v.).
- INCEST:** Sexual intercourse between closely related persons of opposite sex. Apparently every culture forbids what it defines as incest, but the degree of relationship prohibited varies in different cultures.
- INCOMPETENT:** A legal term for a person who cannot be held responsible for his actions because of serious mental illness or mental deficiency.

INCORPORATION: A primitive mental mechanism, operating unconsciously, in which a person, or parts of another person, are symbolically ingested and assimilated. Example: infantile fantasy that the mother's breast has been ingested and is a part of oneself.

INDIVIDUAL PSYCHOLOGY: The system of psychiatric theory, research, and therapy developed by Alfred Adler which stresses *Compensation* and *Overcompensation* (q.v.) for inferiority feelings.

INDUSTRIAL PSYCHOLOGY: The scientific investigation of industrial problems by the methods, concepts, and principles of psychology and utilization of the findings to increase efficiency.

INFANTICIDE: The killing of a newly or recently born child.

INFANTILE PARALYSIS: See *Poliomyelitis*.

INFANTILISM: A condition of body or mind in an older child or adult that is characterized by failure of development or by a regression to an infantile condition.

INFERIORITY COMPLEX: See *Complex*.

INHIBITION: Unconscious interference with or restriction of instinctual drives.

INSANITY: An old, vague, legal term for the psychotic state. Generally connotes (a) mental incompetence, (b) inability to distinguish "right from wrong," and/or (c) a condition that interferes with the individual's ability to care for himself or that constitutes a danger to himself or to others. See *M'Naghten Rule*; *Durham Decision*.

INSIGHT: Self-understanding; a major goal of psychotherapy; the extent of the individual's understanding of the origin, nature, and mechanisms of his attitudes and behavior.

INSOMNIA: Inability to sleep, especially when chronic.

INSTINCT: An inborn drive. The human instincts include those of self-preservation, sexuality, and (for some authors) the *Ego instincts* (q.v.) and the herd or social instincts. See also *Death instinct*.

INSULIN SHOCK THERAPY: See *Shock treatment*.

INSULIN TREATMENT: See *Shock treatment*.

INTEGRATION: The useful organization of both new and old data, experience, and emotional capacities into the personality. Integration also refers to the organization and amalgamation of functions at various levels of *Psychosexual development* (q.v.).

INTELLIGENCE: The potential ability of an individual to understand what he needs to recall and to mobilize and integrate constructively previous learning and experience in meeting new situations. The functional use of intelligence is influenced by emotional factors.

INTELLIGENCE QUOTIENT (I.Q.): An arithmetical figure, determined through psychological testing, which indicates the relation of a person's intellectual performance to the statistical norm of his age-group.

INTELLIGENCE TEST: A series of tasks yielding a score indicative of the intelligence of the individual who attains the score.

INTRAPSYCHIC: That which takes place within the *Psyche* (q.v.) or mind.

INTROJECTION: A mental mechanism, operating unconsciously, whereby loved or hated external objects are taken within oneself symbolically. The converse of *Projection* (q.v.). The process of introjection may serve as a defense against conscious recognition of intolerable hostile impulses. For example, in severe depression, the individual may unconsciously direct unacceptable hatred or aggression toward himself, i.e., toward the introjected object within himself. Related to the more primitive mechanism of *Incorporation* (q.v.).

INTROVERSION: Preoccupation with oneself, with accompanying reduction of interest in the outside world. Roughly the reverse of *Extroversion* (q.v.).

INVOLUTIONAL PSYCHOSIS: A psychotic reaction taking place during the involutional period, climacteric (male) or menopause (female), characterized most commonly by depression and occasionally by paranoid thinking. The course tends to be prolonged, and the condition may be manifested by feelings of guilt, anxiety, agitation, delusional ideas, insomnia, and somatic preoccupation.

I.Q.: See *Intelligence quotient*.

IRRESISTIBLE IMPULSE TEST: A test for determining criminal responsibility. The District of Columbia courts in 1929 (*Smith vs. U.S.*, 36 F 2d 548, 549) supplemented the M'Naghten "right or wrong" test by holding that the accused could not be held criminally responsible if it could be demonstrated that he was impelled to commit the act by an irresistible impulse. The assumption here was that mental illness produces sudden or spontaneous impulses to commit unlawful acts. See also *M'Naghten Rule; Durham Decision*.

JACKSONIAN EPILEPSY: See *Epilepsy*.

JEALOUSY: An attitude or sentiment whose organizing principle is resentment that a beloved person shows affection to a third party.

JUVENILE DELINQUENCY: A relatively minor violation of legal or moral codes by a person under sixteen or eighteen (depending on the state code), bringing him to the attention of a court.

KINESIC: Of, or pertaining to, motion.

KINESIS: Generic term for motion.

KLEPTOMANIA: Compulsive stealing, largely without regard to any apparent material need for the stolen objects.

KORSAKOFF'S PSYCHOSIS (KORSAKOFF'S SYNDROME): A disorder marked by disturbance of attention and memory, as evidenced by *Confabulation* (q.v.), and by involvement of the peripheral nerves. May be due to alcohol, or certain poisons and infections.

LA BELLE INDIFFÉRENCE: (Literally, "the beautiful, or grand, indifference"); seen in certain patients with somatic conversion (*hysteria*); describes patients with inappropriate lack of concern for the implications of their disability. See also *Conversion hysteria* under *Neuroses*.

LABILE: Rapidly shifting emotions.

LANGUAGE BEHAVIOR: Any form of communicative behavior, verbal or nonverbal; any behavior in which language of any sort plays a principal part.

LAPSUS LINGUAE: A slip of the tongue; due to unconscious factors.

LATENCY PERIOD: In psychoanalysis, a phase between the oedipal (or phallic) and adolescent periods of psychosexual development. It is characterized by an apparent standstill in psychosexual development.

LATENT CONTENT: The hidden (unconscious) meaning of conscious thoughts or actions, especially in dreams or fantasies. It is expressed in distorted, disguised, condensed, and symbolic form as the *Manifest content* (q.v.).

LESBIAN: A homosexual woman.

LESBIANISM: Homosexuality in women.

LETHARGY: Morbid drowsiness from which it is difficult to arouse a person; inaction and apathy.

LIBIDO: The psychic drive or energy usually associated with the sexual instinct. (Sexual is used here in the broad sense to include pleasure and love-object seeking.) Also used broadly to connote the psychic energy associated with instincts in general.

LITIGIOUS: Inclined to, or fond of, legal contention; involved or liable to be involved in lawsuits.

LOBOTOMY: See *Psychosurgery*.

LOCOMOTOR ATAXIA: See *Ataxia*.

LOGIC: The branch of philosophy that establishes the criteria by which, granting the correctness of the factual data employed, the worth or validity of reasoning may be judged.

LOGORRHEA: Excessive talking.

LONGEVITY: Long duration of life.

LUNACY: Obsolete legal term for insanity.

LUNATIC: Obsolete legal term for a psychotic person.

LUST: Craving for immoderate self-indulgence; immoderate sexual craving.

LYSERGIC ACID DIETHYLAMIDE (L.S.D.): A drug used to produce psychological changes without gross impairment of memory and orientation; it is one of the drugs producing a state resembling naturally occurring psychosis.

M'NAGHTEN RULE (also **McNAGHTEN**, **McNAUGHTEN**): A legal precedent in English law originating in 1843 (8 Eng. Rep. 718) in the trial of M'Naghten for the murder of the Prime Minister's secretary. He was found not guilty, and the English judges announced that the accused was not responsible for the crime if he was "labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong." This rule became known as the "right and wrong" test, and was widely adopted in the statutes of the English-speaking world. The rule did not take account of the fact that a man might be held to be insane even though he knew the difference between right and wrong. See also *Irresistible impulse test*; *Durham Decision*.

MAGIC: A practice designed to bring supernatural power to bear because the practice is believed to be the inducing cause of that power. Magical thinking and acting are common to almost all psychiatric states.

MALINGERING: A conscious simulation of illness used to avoid a personally unpleasant or intolerable alternative. Regarded in psychiatry as a specific psychopathological symptom.

MANIA: A mental illness marked by heightened excitability, acceleration of thought, speech, and bodily motion, and by elation or grandiosity of mood.

MANIC-DEPRESSIVE PSYCHOSIS: A major emotional illness marked by severe mood swings (elation-depression) and a tendency to remission and recurrence. See *Psychosis*.

DEPRESSED TYPE: Characterized by depression of mood with retardation and inhibition of thinking and physical activity.

MANIC TYPE: Characterized by elation, with over-talkativeness, extremely rapid ideation, and increased motor activity. See also *Flight of ideas*.

MANIFEST CONTENT: The remembered content of a dream or fantasy, or ordinary thoughts and feelings, as opposed to *Latent content* (q.v.) which it conceals and distorts.

MARGINAL MAN: A person who is not a fully participating member of a group; especially, one who stands on the boundary between two groups, uncertain of his group membership.

MARRIAGE COUNSELING: Counseling with primary focus on marital problems. See *Counseling*.

MASCULINE PROTEST: The desire of a female to be a male or to have masculine privileges; or of a male to avoid femininity.

MASOCHISM: Pleasure derived from suffering physical or psychological pain. The pleasure has a sexual basis which may be conscious or unconscious. The suffering may be inflicted by oneself or by others. It may be consciously sought (flagellation) or unconsciously "arranged" or invited. When consciously sexual, it constitutes sexual perversion. It is the converse of *Sadism* (q.v.), and when the two are mixed, it is known as *Sadomasochism* (q.v.).

MASS MEDIA: The instruments of communication that reach large numbers of people with a common message: books, press, radio, television, motion pictures, etc.

MASTURBATION: Manual or other artificial mechanical stimulation of the genitals (penis or clitoris) for the purpose of experiencing pleasurable sensations of sexual excitement.

MATURITY: A vaguely defined condition which may refer to: (1) practical wisdom (intellectual maturity), (2) steady and socially acceptable emotional behavior (emotional maturity), or (3) mastery of effective social techniques (social maturity).

MAYHEM: (in law) The maiming of a person by depriving him of the use of any of his members necessary for self-defense; by extension, maiming by willful disfiguring of the body.

MECHANISM: The way in which any machine or system operates; the doctrine that human behavior is explicable in terms of the laws of physical mechanics. In psychiatry, a more or less permanent way of acting to secure an end. See *Mental mechanisms*.

MEDULLA: The bulblike prolongation upward of the spinal cord, forming the lowest part of the brain and containing nerve centers to control breathing, circulation, and so on.

MEGALOMANIA: A syndrome marked by delusions of great self-importance, wealth, or power.

MELANCHOLIA: Pathologic dejection, usually of psychotic depth.

MEMORY: The general function of reviving or reliving past experience, with more or less definite realization that the present experience is a revival; four phases of memory are recognized: memorizing or learning, retention, recall, and recognition.

MENARCHE: The onset of menstruation in the female life cycle.

MENDEL'S LAW: Also, Mendelian law. The mechanism of inheritance, as observed by Gregor J. Mendel (1822–1884) in breeding experiments with peas. The law is based on three general principles: the existence in the germ plasm of elements called genes that are transmitted as unit characters, the segregation of the genes in the reproductive process, and genic dominance.

MENINGES: Three membranes that cover the brain and the spinal cord.

MENINGITIS: Inflammation of the meninges.

MENINGOCOCCUS: A streptococcal organism that causes meningitis.

MENOPAUSE: The period of natural cessation of the menstrual cycle; "change of life." See *Climacteric*.

MENSTRUATION: The monthly discharge of blood from the uterus of a sexually mature woman.

MENTAL ABILITY: Semipopular term for intelligence. See *Intelligence*.

MENTAL AGE: The age level of mental ability determined by standard intelligence tests; distinguished from chronologic age.

MENTAL DEFICIENCY: Lacking in intelligence to a degree that one cannot make an average adjustment to life. Emotional conflict usually complicates the condition. The need for institutional treatment and care is proportional to the degree of impairment and the level of emotional adjustment.

Borderline Cases have I.Q.'s of 70–85; *Morons*, I.Q.'s of 50–69; *Imbeciles*, I.Q.'s of 20–49; *Idiots*, I.Q.'s of 20 and below. Current usage tends to abandon these terms in favor of *Slight*, *Moderate*, and *Severe* degrees of mental deficiency.

MENTAL DEVELOPMENT: The progressive changes in mental organization of an individual from conception to death; especially, the progressive changes between birth and maturity or during any specified part of the life span.

MENTAL DISORDER: Any grave or disabling failure of adjustment, whether relatively temporary or chronic. The term does not include mental deficiency; it does include psychosis and neurosis.

MENTAL DISORDERS, CLASSIFICATION OF: See *Nomenclature*.

MENTAL DYNAMISM: See *Mental mechanisms*.

MENTAL HEALTH: See *Emotional health*.

MENTAL HOSPITAL: A hospital for the care and treatment of patients with mental illnesses.

MENTAL HYGIENE: Measures to reduce the incidence of mental illness through prevention and early treatment and to promote mental health.

MENTAL ILLNESS: A disorder of behavior; a breakdown of adjustment so severe that psychotherapy is indicated.

MENTAL MECHANISMS: Also called *Defense mechanisms* and *Mental dynamisms*. Specific intrapsychic defensive processes, operating unconsciously, which are employed to seek resolution of emotional conflict and freedom from anxiety. Conscious efforts are frequently made for the same reasons, but true mental mechanisms are out of awareness (unconscious). Some of the common mental mechanisms described in this glossary are: *compensation, conversion, denial, displacement, dissociation, idealization, identification, incorporation, introjection, projection, rationalization, reaction formation, regression, repression, sublimation, substitution, symbolization, undoing*.

MENTAL RETARDATION: See *Retardation*.

MENTAL TEST: Any measure of individual differences in behavior. See *Intelligence test*.

MEPROBAMATE: Generic name for *Equanil* (q.v.) and *Miltown* (q.v.).

MESCALINE: A poisonous alkaloid producing intoxication with delusions of color and music. Used today to produce an experimental or model psychosis.

- MESMERISM:** Early term for *Hypnosis* (q.v.); named after Anton Mesmer (1733–1815).
- MESODERM:** The middle of the three cell layers in the embryo, which develops into the bones and muscles.
- MESOMORPHIC:** Pertaining to bodily structures developed from the embryonic *Mesoderm* (q.v.).
Mesomorphic Type: A highly developed skeletal structure, thick skin, sturdy upright posture. See *Ectomorphic*; *Endomorphic*.
- METABOLISM:** The sum of the processes concerned in building up and breaking down of protoplasm, i.e., of living cells or tissues.
- METRAZOL THERAPY:** A type of shock treatment by intravenous administration of metrazol, producing generalized convulsions; now seldom used.
- MICROCEPHALY:** Smallness of the head associated with mental deficiency.
- MIDBRAIN:** That part of the brain lying beneath, and surrounded by, the cerebrum.
- MIGRAINE:** An illness characterized by recurrent, severe, and usually one-sided headaches, often associated with nausea, vomiting, and visual disturbances. May be due to unconscious emotional conflicts.
- MILIEU THERAPY:** Treatment of mental disorders, in which the setting or environment plays a primary part.
- MILITARY PSYCHIATRY:** A specialization within psychiatry, concerned with individuals in a military environment.
- MILTOWN:** Proprietary name for *Meproamate*, used as a muscle-relaxing and tranquilizing agent.
- MIRROR REVERSAL:** The right-left shift in apparent position perceived when an object is viewed in a mirror. In reading, there may be reversal of single letters, of the order of letters in a word, or of the order of a whole line.
- MOB:** A crowd in which the participants' normal control of their actions gives way to highly emotionalized and violent action.

MODALITY: (sense modality) A sense department, more inclusive than sense quality, of data that qualitatively resemble each other more than they resemble other sense data.

MONGOLISM: A variety of congenital mental deficiency. So called because of the superficial resemblance to Oriental facial characteristics.

MONOMANIA: Obsolete term formerly applied to paranoid conditions.

MONONUCLEOSIS: The presence in the blood of single-celled white corpuscles in abnormal number.

MONOZYGOTIC TWINS: Identical twins, i.e., twins formed by the division of a single fertilized egg.

MORBIDITY: Disease, sickness.

MORON: See *Mental deficiency*.

MORPHINE: The principal alkaloid of *Opium* (q.v.).

MORPHOLOGY: The biological science that deals with bodily forms and structures.

MOTHER FIXATION: Attachment to the mother, developed in infancy and early childhood, which persists in neurotic form, with corollary inability to form normal attachments to other persons.

MOTHER SURROGATE: One who is reacted to as if she stood in place of a mother.

MOTIVATION: The general term denoting that the direction and strength of a person's acts are partly determined by his own nature and/or his internal state, in distinction to ability and stimulus.

MOURNING: Act of sorrowing or expressing grief, especially for a person's death. It may be normal or neurotic.

MULTIPLE PERSONALITY: See *Personality, multiple*.

MULTIPLE SCLEROSIS: A diseased condition characterized by hardening of many spots in the brain and cord, with resulting impairment of behavior.

- MUSIC THERAPY:** Use of music in the treatment of mental disorders.
- MUTISM:** Lack of speech development resulting from congenital or early deafness, or from loss or impairment of motor function (akinesic mutism); inhibition, voluntary or involuntary, of speech.
- MYSOLINE:** A synthetic drug used in the treatment of petit mal *Epilepsy* (q.v.).
- MYSOPHOBIA:** The morbid fear of dirt, germs, or contamination.
- MYSTICISM:** The doctrine that there is a kind of knowledge in addition to that received through the senses or by thinking.
- MYXEDEMA:** A disorder of adults and older children in which there is reduced thyroid secretion, low basal metabolism, apathy, and lethargy.
- NARCISSISM (also NARCISM):** Self-love. In a broader sense indicates a degree of self-interest which is normal to early childhood but pathologic when seen in similar degree in adulthood.
- NARCOANALYSIS:** Similar to narcosynthesis, in which psychotherapy is conducted under the influence of drugs.
- NARCOLEPSY:** Brief, uncontrollable episodes of sleeping.
- NARCOSIS:** The sleeplike state induced by a narcotic drug.
- NARCOSYNTHESIS:** Psychotherapeutic treatment originally used in acute combat cases under partial anesthesia, e.g., Sodium Amytal or Sodium Pentothal.
- NARCOTIC:** A drug which, used in moderate doses, produces sound sleep, relieves pain, and allays sensibility.
- NATURAL CHILDBIRTH:** Childbirth in which delivery is facilitated by consciously controlled musculature.
- NATUROPATH:** Practitioner of a system of treating disease which emphasizes assisting nature and sometimes includes the use of herbs, vitamins, and salts, and of manipulation and electrical treatment.
- NECROPHILIA:** Sexual attraction to corpses.

NEGATIVE FEELINGS: In psychiatry, hostile, unfriendly feelings.

NEGATIVISM: Perverse opposition and resistance to suggestions or advice. Often observed in people who subjectively feel "pushed around." Seen normally in late infancy. A common symptom in *Catatonic schizophrenia* (q.v. under *Schizophrenia*).

NEMBUTAL: Proprietary name of pentobarbital sodium, used as a hypnotic and sedative.

NEOLOGISM: In psychiatry, a new word or condensed combination of several words coined by a patient to express a highly complex meaning related to his conflicts; not readily understood by others; common in schizophrenia.

NEURON: The single cell which is the fundamental unit of structure of nerve tissue. Each neuron consists of a central portion, the cell body, the dendrite, and the axon.

NEUROPHYSIOLOGY: The branch of physiology that deals with the nervous system.

NERVOUS BREAKDOWN: A nonmedical, nonspecific term for emotional illness; primarily, a euphemism for psychiatric illness or psychosis.

NERVOUS SYSTEM: All the organs of the body that are composed of nerve tissue. The nervous system is subdivided: structurally into central nervous system and peripheral nervous system; and functionally into autonomic and somatic divisions.

NEURASTHENIA: See under *Neuroses*.

NEUROLOGIST: A physician with postgraduate training and experience in the field of organic diseases of the nervous system, and whose professional endeavors are primarily concentrated in this area.

NEUROLOGY: The branch of medical science devoted to the anatomy, physiology, and pathology of the nervous system.

NEUROPSYCHIATRY: Combination of the specialties of neurology and psychiatry.

NEUROSES: Emotional maladaptations due to unresolved unconscious conflicts. One of the two major categories of emotional illness, the other being *Psychosis* (q.v.). A neurosis is usually less severe than a psychosis, with minimal loss of contact with reality. Thinking and judgment may be impaired. A neurotic illness represents the attempted resolution of unconscious emotional conflicts in a manner that handicaps the effectiveness of a person in living. Types of neuroses are usually classified according to the particular symptoms which predominate. Common types are:

ANXIETY NEUROSIS: Characterized primarily by direct experiencing of anxiety, which may have an acute or gradual onset, with subjective uneasiness or apprehension out of proportion to any apparent external cause. The anxiety is uncontrollable, and the utilization of various specific defense mechanisms common in other neuroses is minor.

CONVERSION HYSTERIA (SOMATIC CONVERSION): Unacceptable unconscious impulses are converted into bodily symptoms. Instead of being experienced consciously, the emotional conflict is expressed by physical symptoms. In a broad sense, all neurotic reactions may be regarded as somatic, physiologic, or psychologic "conversions," but technically the term is usually restricted to its somatic aspects. See also *Conversion*.

DISSOCIATIVE REACTION: Characterized by such dissociated behavior as amnesia, sleepwalking, and dream states. Superficially, sometimes resembles schizophrenia. See also *Dissociation*.

OBSESSIVE-COMPULSIVE NEUROSIS: Reaction patterns associated with the intrusion of insistent, repetitive, and unwanted ideas, or of repetitive, unwelcome impulses to perform certain acts. The afflicted person may feel compelled to carry out rituals such as repeated hand-washing, touching, or counting.

PHOBIC REACTION: Characterized by a continuing, specific, irrational fear out of proportion to apparent stimuli. See *Phobia*.

NEUROTIC DEPRESSION: A general term covering various types of neurotic depressive reactions in which insight is impaired but not so severely as in psychotic depression. A neurotic depression may progress to a psychotic depression. See *Depression*.

REACTIVE DEPRESSION: A neurotic depressive reaction apparently precipitated by specific traumatic situational loss.

CHARACTER NEUROSIS: See *Character disorder*.

Other terms less commonly used are:

HYPOCHONDRIA: Persistent overconcern with the state of physical or emotional health accompanied by various bodily complaints without demonstrable organic pathology.

NEURASTHENIA: Marked by symptoms of fatigue, feelings of inadequacy, and poor concentration; originally regarded as due to weakness or exhaustion of the nervous system.

TRAUMATIC NEUROSIS: The term encompasses combat, occupational, and compensation neuroses. These are neurotic reactions which have been attributed to or which follow a situational traumatic event, or series of events. Usually the event has some specific and symbolic emotional significance for the patient, which may be reinforced by *Secondary gain* (q.v.).

NEUROTOGENIC: Producing or favoring neurosis.

NIGHTMARE: A dream full of fear and anxiety depicting fearful events.

NIGHT TERROR: A nightmare from which the dreamer (usually a child) awakes screaming with fright and in which the terror continues for some time during a state of semiconsciousness.

NIHILISM: In psychiatry, the delusion of nonexistence of the self or part of the self.

NIRVANA: According to Buddhist teaching, the goal of life in which all desires are extinguished and individuality is merged with the cosmos. Psychoanalysts equate the nirvana principle, based on the loss of individuality, with Freud's death instinct. See *Death instinct*.

NOCTURNAL EMISSION: Loss of semen during sleep.

NOMENCLATURE: In psychiatry, the standard nomenclature officially supported by the American Psychiatric Association for the classification of mental disorders.

NORADRENALIN: A principle in the adrenal medulla associated with adrenalin, but differing from it in its vascular action; purely a vasoconstrictor, i.e., causing constriction of the blood vessels.

NOSOLOGY: Medical science of classification of diseases.

NURTURANCE: The tendency that leads one to provide nurture, i.e., food, shelter, and other care, to the young or to the weak and incapable.

NYMPHOMANIA: Pathologic and exaggerated sexual drive or excitement in the female. The female counterpart of *Satyriasis* (q.v.).

OBESITY: The state of being overweight; may be the result of emotional factors leading to overeating.

OBJECT BEHAVIOR: The socially standardized behavior in relation to a specific object. The individual may not know or may elect to ignore such behavior.

OBJECTIVITY: Freedom from bias; impersonality; judgment unaffected by feeling.

OBSCENITY: Gestures, language, or pictures that violate the established conventions of what may properly be expressed under certain conditions in respect to sex and the excretory functions. Obscenity obviously varies with the circumstances and with the culture.

OBSESSION: Persistent, unwanted idea or impulse that cannot be eliminated by logic or reasoning.

OBSESSIVE-COMPULSIVE NEUROSIS: See under *Neuroses*.

- OBSESSIVE PERSONALITY:** A type of character structure in which there is a pattern of several of the obsessive groups of personality traits or defenses, such as excessive self-imposed orderliness, worry over trifles, indecisiveness, and perfectionism. These may or may not be sufficiently marked to interfere with living, or to limit normal satisfactions and social adjustment.
- OCCUPATIONAL THERAPY:** An adjunctive therapy commonly used in mental hospitals. It provides opportunity for partial *Sublimation* and/or *Acting out* (q.v.) of patients' unconscious conflicts, and stimulates interests through supervised handicrafts or other activities. Other similar therapies are music, recreation, drama, dance, and bibliotherapy.
- OEDIPUS COMPLEX:** See *Complex*.
- OLD AGE:** The fifth and last of the arbitrary divisions of the life span in terms of chronological age; generally, from sixty-five years on.
- OMNIPOTENCE (of thought):** Acting as if mere wishes or thoughts were realities, or as if they must have results in the external world.
- ONANISM:** Incomplete sexual relations with withdrawal just prior to emission; *Coitus interruptus*. Incorrectly used as synonym for masturbation.
- ONTOGENESIS:** The origin, or origin and development, of an individual organism or of one of its organs or functions.
- OPIUM:** A narcotic drug, produced from one species of poppy, which depresses the higher nerve centers and creates a feeling of euphoria.
- OPTIMISM:** A highly general attitude or personality trait that sees good in most objects and events, and expects outcomes to be favorable.
- ORAL STAGE:** Includes both the oral erotic and oral sadistic phases of infantile psychosexual development, lasting from birth to twelve months or longer. The oral erotic phase is the initial pleasurable experience of nursing. The oral sadistic phase is the subsequent aggressive (biting) phase. Both oral erotism and sadism normally continue in later life in disguised and sublimated forms.

- OREXIS:** The feeling and striving aspect of an act as contrasted with the intellectual.
- ORGANIC DISEASE:** Characterized by demonstrable structural or biochemical changes in the tissues and organs of the body as distinguished from emotional illness. Organic disease is generally accompanied by notable emotional reactions which may become severe; or, alternatively, emotional illness, long continued, may result in organic changes.
- ORGANICIST:** One who emphasizes the importance of organic relations; in medicine, one who adheres to the theory that disease is always associated with a material lesion of an organ.
- ORGANIC PSYCHOSIS:** A mental illness of psychotic depth resulting from defect, damage, infection, tumor, or other organic pathology of the brain. See *Psychosis*.
- ORGASM:** A group of involuntary movements in the genital organs, accompanied by pleasure and strong sex feeling. It is the releasing climax of coition but may be experienced under other conditions.
- ORGONE:** A term used by the psychiatrist, Wilhelm Reich, for the life energy, which he believed to be specific and identifiable.
- ORIENTATION:** Awareness of oneself in relation to time, place, and person.
- ORTHOPSYCHIATRY:** Psychiatry concerned with the study of children. Emphasis is placed on preventive techniques to promote normal, healthy emotional growth and development.
- OTOLARYNGOLOGIST:** A physician specializing in the branch of medicine which treats diseases of the ear and larynx.
- OVERCOMPENSATION:** A conscious or unconscious process in which a real or fancied physical or psychologic deficit inspires exaggerated correction.
- OVERDETERMINATION:** In psychiatry, a term indicating the multiple causality of a single emotional reaction or symptom. The symptom expresses the confluence and condensation of unconscious needs, drives, and defenses.
- OVERPROTECTION:** Providing greater care for an infant or child than is necessary; inclusive reference to pampering, indulgence, oversolicitude, etc.

PACK: A sedative measure in psychiatric hydrotherapy for calming overexcited or agitated patients.

PALSY: See *Paralysis agitans*.

PANIC: In psychiatry, an attack of acute, intense, and overwhelming anxiety, accompanied by a considerable degree of personality disorganization. See *Anxiety*.

PANPHOBIA: Multiple *Phobia* (q.v.).

PARALYSIS: Loss or impairment of a function. Unless qualified, a motor function is usually referred to. Various kinds of paralysis are named by using the combining form, plegia.

PARALYSIS AGITANS: A paralytic disorder characterized by continuous coarse tremor of the hands. The condition is commonly called palsy. Synonym: *Parkinson's disease*.

PARAMETER: In psychology, any constant that defines the curve of the equation for some psychological function, as learning, growth; such a constant is the mathematical expression of the change induced in the curve by a change of materials, experimental procedures, etc. In psychoanalysis, the differentiating character of a technique of analysis used for a particular disorder or for a particular patient.

PARANOIA: Rare psychotic disorder which develops slowly and becomes chronic. It is characterized by an intricate and internally logical system of persecutory and/or grandiose delusions. The system stands by itself and does not interfere with the remainder of the personality, which continues essentially normal and apparently intact. See *Paranoid type* under *Schizophrenia*; *Paranoid state* (q.v.).

PARANOID: An adjective derived from the noun *Paranoia* (q.v.). Characterized by oversuspiciousness but not easily proved delusional. Prevalently used to describe any grandiose or persecutory delusions.

PARANOID PERSONALITY: A personality disorder somewhat similar to paranoid schizophrenia but without the deterioration or systematized delusions.

PARANOID STATE: Characterized by paranoid delusions but not so internally logically systematized as in true paranoia nor so bizarre or disorganized as in schizophrenic paranoid reactions. May be of short duration, or persistent and chronic. See *Paranoia*; *Schizophrenia*.

PARAPLEGIA: Paralysis of the lower limbs.

PARAPSYCHOLOGY: The study of metapsychic (also *Psi*) phenomena; namely, relationships between persons and events which seemingly occur extraphysically, without the apparent intervention of any of the five senses. See also *Psychokinesis*; *Extrasensory perception (E.S.P.)*.

PARATAXIC DISTORTION: See under *Distortion*.

PARESIS, GENERAL: A psychiatric disorder characterized by mental and physical symptoms; always due to syphilis of the central nervous system.

PARKINSON'S DISEASE: See *Paralysis agitans*.

PARTHENOGENESIS: Reproduction from an unfertilized egg; a modification of sexual reproduction.

PARTURITION: The act of giving birth to offspring.

PASSIVE-AGGRESSIVE PERSONALITY: Characterized by aggressive behavior exhibited in passive ways, such as pouting, stubbornness, procrastination, and obstructionism. May be considered a form of *Character disorder* (q.v.).

PASSIVE-DEPENDENT PERSONALITY: Characterized by lack of self-confidence, indecisiveness, and emotional dependency. May be considered a form of *Character disorder* (q.v.).

PASTORAL COUNSELING: Counseling by a religious leader.

PATHOGNOMONIC: A general medical term which is applied to a symptom or group of symptoms that are specifically diagnostic of a disease entity. Similar to *Syndrome* (q.v.).

PAVOR NOCTURNUS: Nightmare.

PEDERASTY: Homosexual intercourse between man and boy, by anus. To be distinguished from *Sodomy* (q.v.).

PEDOPHILIA: An adult's sexual attraction to children.

PENIS ENVY: Literally, envy by the female of the penis of the male. More generally, the female wish for male attributes, position, or advantages. Believed by many to be a significant factor in female character development.

PENOLOGY: The study or art of treating those convicted of crime. The treatment may be conceived as deterrent or as reformative.

PERCEPTION: The mental process by which the nature of an object is recognized through the association of a memory of its other qualities, with the special sense (sight, taste, etc.) bringing it to consciousness.

PERFECTIONISM: The practice of demanding of oneself or others a higher quality of performance than is required by the situation.

PERFORMANCE TEST: A test in which the role of language is minimized; the task requires overt motor responses other than verbal. See *Test, Psychological or mental*.

PERMISSIVENESS: The attitude that grants freedom of choice and expression to another person out of respect for his personality.

PERSECUTION COMPLEX: A delusion that other persons are deliberately and unfairly causing the person's efforts to fail or are in some way inflicting hardships on him. See *Delusion*.

PERSEVERATION: Similar to *Stereotypy* (q.v.).

PERSONA: In Jungian psychology, the personality mask or façade which each person presents to the outside world. See also *Anima*.

PERSONALITY: The sum total of the individual's internal and external patterns of adjustment to life.

PERSONALITY DISORDERS: A term used to include a broad category of disorders characterized by developmental defects or pathological trends. There is minimal subjective anxiety and little or no sense of distress. For example, the terms *Passive-aggressive personality* (q.v.) and *Compulsive personality* (q.v.) fall into this category. See also *Character disorder; Psychopath*.

PERSONALITY, MULTIPLE: A rare type of major dissociative reaction in which the individual adopts two or more different personalities. These are separate and compartmentalized, with total amnesia for the one, or ones, not in awareness.

PERSUASION: In psychiatry, a therapeutic approach based on direct suggestion and guidance intended to change patients' attitudes, behavior, and goals.

PERVERSION: Sexual deviation.

PETIT MAL: See *Epilepsy*.

PHALLIC STAGE: The period of psychosexual development from the age of about two and a half to six years during which sexual interest, curiosity, and pleasurable experience center about the penis, and in girls, to a lesser extent, the clitoris. See also *Oral stage*; *Anal erotism*; *Latency period*.

PHANTASY: See *Fantasy*.

PHANTOM LIMB: The persistent or recurrent feeling, experienced by many amputees, of sensations as if from the missing member.

PHENMETRAZINE: A drug used for steady, progressive weight loss in overweight patients, and for psychotic disorders.

PHENOBARBITAL: A white crystalline powder (phenyl-ethyl-barbituric acid) used as a sedative or hypnotic drug.

PHENOMENOLOGY: A theoretical point of view that advocates the study of phenomena, in the sense of happenings without regard to their causes, or of direct experience taken at its face value: the view is that behavior is determined by such phenomena or experiences rather than by external, objective reality.

PHENYLKETONURIA: A hereditary disorder of phenylalanine metabolism, which appears in infancy and has as its most striking manifestation severe mental deficiency.

PHOBIA: An obsessive, persistent, unrealistic fear of an external object or situation such as heights, open spaces, dirt, and animals. The fear is believed to arise through a process of displacing an internal (unconscious) conflict to an external object symbolically related to the conflict. See *Displacement*.

PHOBIC REACTION: See under *Neuroses*.

PHRENOLOGY: Abandoned theory of relationship between bony structure of the skull and mental traits.

PHYLOGENETIC: Pertaining to the origin and development of a characteristic in the race or other biological division; pertaining to that which is hereditary in a species.

PHYSICALIST: One who holds the philosophical view that all meaningful propositions can be expressed without distortion in the language of physical science; one who holds that human thoughts and acts are determined by physical laws.

PICK'S DISEASE: A presenile degenerative disease of the brain affecting the cerebral cortex, particularly the frontal lobes. Symptoms include intellectual deterioration, emotional instability, and loss of social adjustment. See also *Alzheimer's disease*, which is similar.

PILOMOTOR RESPONSE: Technical term for goose pimples.

PINEAL GLAND: A small structure, lying just above the thalamic region, very nearly at the geometric center of the brain. Its function is unknown.

PITUITARY GLAND: A very important compound endocrine gland lying at the base of the brain. It has many functions and is sometimes called the master gland because of its influence on the other endocrines.

PLACEBO: A preparation containing no medicine (or no medicine related to the complaint) administered to cause the patient to believe he is receiving treatment. Placebo effects include the psychologic and psychophysiologic benefits and undesirable reactions which reflect the patient's expectations.

PLANNED PARENTHOOD: Voluntary regulation of the number and spacing of offspring through contraception.

PLAY THERAPY: A psychotherapeutic approach to children's emotional disorders in which the observation and interpretation of the child's use of his play materials and his fantasy in his games and play form part of the therapy.

- PLEASURE PRINCIPLE:** The basic psychoanalytic concept that man instinctually seeks to avoid pain and discomfort, and strives for gratification and pleasure. In personality development theories the pleasure principle antedates and subsequently comes in conflict with the *Reality principle* (q.v.).
- POLIOMYELITIS:** An acute infectious disease caused by a virus which attacks the gray matter of the spinal cord, resulting in extensive neural symptoms.
- POLYPHAGIA:** Pathological overeating.
- PORNOGRAPHY:** Expression by word or image of whatever the user of the term regards as *Obscenity* (q.v.).
- PORPHYRIA:** A metabolic disease characterized by abdominal, neurologic, and psychiatric symptoms and the presence of porphyrin in the blood.
- POSITIVE FEELINGS:** In psychiatry, warm, friendly feelings, as opposed to negative, hostile feelings.
- POSTHYPNOTIC SUGGESTION:** The process whereby a person after coming out of the hypnotic trance carries out some action that has been suggested to him during the trance-state.
- POSTPARTUM DEPRESSION:** Depression following childbirth.
- POTENCY:** The male's ability to carry out normal heterosexual relations.
- PREADOLESCENCE:** A variable period, synonymous with late childhood; the two years before puberty.
- PRECONSCIOUS:** Referring to thoughts which are not in immediate awareness, but which can be recalled by conscious effort. See also *Foreconscious*.
- PREFRONTAL LOBOTOMY:** A type of *Psychosurgery* (q.v.).
- PREMATURE INFANT:** A viable fetus delivered before the end of the normal gestation period.
- PREMENSTRUAL TENSION:** Physiological or psychic symptoms, differing from woman to woman, in the three or four days preceding the menstrual period.

PRIMAL SCENE: In psychoanalytic theory, the real or fancied observation by the infant of parental or other heterosexual intercourse.

PRIMARY GAIN: A term used in connection with neurotic symptoms. The basic internal psychologic gain of an emotional illness. The concept is that mental symptoms, both normal and psychopathologic, develop defensively in largely unconscious endeavors to cope with or to resolve unconscious conflicts. Such symptoms are characteristically the result of a compromise between a pleasure-seeking, instinctual wish and an opposing, moral prohibition which has created an unconscious conflict. Primary gain refers to the element of unconscious gratification provided by the compromise (symptom) as well as to the lessening of guilt and fear which it provides. All mental mechanisms operate in the service of the primary gain, and the need for such gain may be thought of as responsible for the initiation of an emotional illness. In contradistinction, the *Secondary gain* (q.v.) is that which is secured from a symptom or an illness which is already established. See *Mental mechanisms*.

PRIMARY PROCESS: The type of mental activity and thought process which is characteristic of unconscious mental life at all times and which in infancy characterizes conscious mental life as well. It is marked by the free discharge of psychic energy and excitation without regard to the demands of the environment, reality, or logic.

PRISON PSYCHOSIS: Refers to severe emotional reactions of psychotic depth precipitated by actual or anticipated incarceration.

PROBLEM CHILD: One whose conduct differs from socially acceptable standards so greatly that he cannot be dealt with by "common sense" or the usual techniques.

PROGNOSIS: Estimate or prediction of the course, outcome, and duration of an illness.

PROJECTION: A mental mechanism, operating unconsciously, whereby that which is emotionally unacceptable in the self is unconsciously rejected and attributed (projected) to others. The attributes so assigned to another are real to the self and the self reacts accordingly.

- PROJECTIVE TEST:** A type of psychological test in which the material presented to the subject is of the kind that evokes a response determined by his prevailing mood and personality characteristics. Interpretation of the responses requires much training.
- PROMISCUITY:** Nonselective sexual intercourse.
- PROSTITUTION:** Promiscuous sexual intercourse for financial gain; figuratively, compromising ideals in order to gain an advantage.
- PSEUDO-FEEBLEMINDEDNESS:** Feeble-mindedness indicated by a low I.Q. but actually nonexistent. Psychological and emotional factors may result in a low I.Q. score that does not represent the actual endowment. See *Feeble-mindedness*.
- PSORIASIS:** A skin disease consisting of an eruption of red patches, mainly on the elbows and knees.
- PSYCHASTHENIA:** Largely obsolete term including obsessions, compulsions, doubts, feelings of inadequacy, and phobias. See also *Neurasthenia* under *Neuroses*.
- PSYCHE:** The mind, in distinction to the soma, or body.
- PSYCHIATRIC INTERVIEW:** A talk between therapist and patient designed to elicit information as an aid to diagnosis and treatment.
- PSYCHIATRIC SOCIAL WORKER:** A social worker trained to work with patients and their families on problems of mental health and illness, usually in close association with psychiatrists and clinical psychologists.
- PSYCHIATRIST:** A doctor of medicine with postgraduate training and experience in the field of emotional illness and mental disorders.
- PSYCHIATRY:** The medical science which deals with the origin, diagnosis, prevention, and treatment of emotional illness and asocial behavior. It also includes such special fields as mental retardation, the emotional components of physical disorders, mental hospital administration, and the legal aspects of psychiatric disorders. See also *Descriptive psychiatry*; *Dynamic psychiatry*.
- PSYCHIC:** A general term for all the phenomena constituting the subject matter of psychology. Pertaining to mind, person, self, psyche.

PSYCHIC DETERMINISM: See *Determinism*.

PSYCHIC ENERGIZER: A term used to describe a drug that is intended to raise mood and increase feeling of well-being.

PSYCHOANALYSIS: A psychologic theory of human development and behavior; a method of research; and a system of psychotherapy, originally described by Sigmund Freud. In psychoanalysis, through free association and dream interpretation, emotions and behavior are traced to repressed instinctual drives in the unconscious. Psychoanalytic treatment seeks to modify emotions and behavior by bringing into awareness the origin and effects of unconscious emotional conflicts in the hope of eliminating or diminishing them.

PSYCHOANALYST: A psychiatrist with additional training in psychoanalysis, who employs the techniques of psychoanalytic therapy.

PSYCHOBIOLOGY (Meyer): The concept of the individual as a total biologic unit in which total personality development and functioning from birth is studied longitudinally. Assets and liabilities of the personality are identified and through the process of *Distributive analysis and synthesis* (q.v.) effort is made to effect better utilization of the individual's assets with consequent diminution of the liabilities.

PSYCHODIAGNOSTICS: The interpretation of behavior signs (gait, posture, gestures, facial expressions, etc.) and of other anatomical signs as indicators of personality and character.

PSYCHODRAMA: A technique of group psychotherapy in which individuals dramatize their emotional problems.

PSYCHODYNAMICS: The systematized knowledge and theory of human behavior and its motivation, the study of which depends largely upon the functional significance of emotion. Psychodynamics recognizes the role of unconscious motivation in human behavior. It is a predictive science, based on the assumption that a person's total makeup and probable reactions at any given moment are the product of past interactions between his specific genetic endowment and the environment in which he has lived from conception onward.

PSYCHOGENESIS: Production or causation of a symptom or illness by mental or psychic factors as opposed to organic ones.

PSYCHOKINESIS: The theory that directed thought processes can influence an event, as for example, by determining what number will show in a throw of dice. See also *Parapsychology*; *Extrasensory perception* (E.S.P.).

PSYCHOLOGIST: One who specializes in psychology. The psychologist generally holds a graduate academic degree (Ph.D. or M.A.), but does not have a medical degree (M.D.) and is not eligible for medical licensure. See *Psychiatrist*.

PSYCHOLOGY: A science dealing with the study of mental processes and behavior in man and animal.

PSYCHOLOGY, ANALYTIC (Jung): See *Analytic psychology*.

PSYCHOLOGY, INDIVIDUAL (Adler): See *Individual psychology*.

PSYCHOMETRY: The science of testing and measuring mental and psychological ability, efficiency, potentials, and functioning including psychopathologic components.

PSYCHOMOTOR: Pertaining to the motor effects of psychical processes.

PSYCHOMOTOR EXCITEMENT: Generalized physical and emotional overactivity in response to internal and/or external stimuli as in a hypomanic state.

PSYCHOMOTOR RETARDATION: A generalized retardation of physical and emotional reactions. The opposite of *Psychomotor excitement* (q.v.).

PSYCHONEUROSIS: See *Neuroses*.

PSYCHOPATH: A person whose behavior is predominantly amoral or antisocial and characterized by impulsive, irresponsible actions satisfying only immediate and narcissistic interests without concern for obvious and implicit social consequences accompanied by minimal outward evidence of anxiety or guilt. Increasingly considered a poor and inexact term.

PSYCHOPATHIC PERSONALITY: See *Psychopath*.

PSYCHOPATHOLOGY: A science dealing with morbid processes of the psyche or mind in terms of their development (psychogenesis).

PSYCHOPHARMACOLOGY: An interdisciplinary science that is concerned with the study of the effects of drugs on normal and abnormal behavior; also used more specifically to refer to chemotherapy of mental illness.

PSYCHOPHYSIOLOGIC DISORDER: A recent term for the morbid physiologic expression of emotional disorders. In general, a substitute term for "psychosomatic disorder" or "somatization reaction."

PSYCHOSEXUAL DEVELOPMENT: The changes and stages which characterize the development of the psychological aspect of sexuality during the period from birth to adult life. Synonym: libidinal development. See also *Libido*.

PSYCHOSIS: A severe emotional illness in which there is a departure from normal patterns of thinking, feeling, and acting. Commonly characterized by loss of contact with reality, distortion of perception, regressive behavior and attitudes, diminished control of elementary impulses and desires, abnormal mental content including delusions and hallucinations. Chronic and generalized personality deterioration may occur. May require commitment to a mental hospital. This is one of the two major categories of emotional illness, the other being *Neuroses* (q.v.).

PSYCHOSOMATIC: Adjective to denote the constant and inseparable interaction of the psyche (mind) and the soma (body). Most commonly used to refer to illnesses in which the manifestations are primarily physical with at least a partial emotional etiology.

PSYCHOSOMATIC MEDICINE: Medical practice that emphasizes the role of psychic factors in many diseases or in maintaining health.

PSYCHOSURGERY: Treatment of serious psychiatric disorders by brain surgery. Certain brain nerve fibers are cut to reduce the tension and distress associated with chronic emotional suffering.

PSYCHOTHERAPY: The generic term for any type of treatment which is based primarily upon verbal or nonverbal communication with the patient, in distinction to the use of drugs, surgery, or physical measures, such as electroshock or insulin shock, hydrotherapy, and others. Most physicians regard intensive psychotherapy as a medical responsibility.

- PSYCHOTIC:** Pertaining to a psychosis; characterizing a certain behavior pattern as symptomatic of psychotic disorder or (at least) as strongly resembling the behavior of such a disorder. See *Psychosis*.
- PSYCHOTOMIMETIC DRUGS:** Drugs that produce psychological changes, not including impairment of memory and orientation, in a high proportion of subjects exposed to such drugs. See *Hallucinogen*.
- PUBERTY:** The period during which the generative organs become capable of functioning and the person develops secondary sex characters; usually reckoned as the first subphase of adolescence.
- PUERPERAL PSYCHOSIS:** A psychotic episode occurring in the period after childbirth.
- PUNCH-DRUNK:** Relates to the pattern of symptoms consequent upon many brain concussions; there is disturbance of gait and mental confusion or cloudiness. Often observed in pugilists.
- PUNISHMENT:** The infliction of a penalty; the penalty may be any kind of dissatisfaction, a painful stimulus (physical or social), or a denial or removal of a satisfaction. Punishment may be inflicted as retaliation, as deterrent, and/or as a motivation to learning.
- PYROMANIA:** Morbid compulsion to set fires.
- PYROMANIAC:** One who suffers from pyromania; a "firebug."
- RAGE:** Violent or intense anger, marked by threatened or actual attack. See *Anger*.
- RAPPORT:** A comfortable and unconstrained relationship of mutual confidence between two or more persons, especially between tester and testee, counselor and client, teacher and class.
- RATIONALIZATION:** A mental mechanism, operating unconsciously, in which the individual attempts to justify or make consciously tolerable, by plausible means, feelings, behavior, and motives which would otherwise be intolerable. Not to be confused with conscious evasion or dissimulation. See also *Projection*.
- RAUWOLFIA:** A genus of the dogbane family, the dried root of which is said to reduce blood pressure in arterial hypertension. Also used in the treatment of psychotic patients. The drug was used in medicine in India for centuries.

REACTION FORMATION: A mental mechanism, operating unconsciously, wherein attitudes and behavior are adopted which are the opposites of impulses the individual disowns either consciously or unconsciously, e.g., excessive moral zeal may be the product of strong but repressed asocial impulses.

REACTIVE DEPRESSION: See under *Neuroses*.

READING DISABILITY: A marked inability to read as well as expected, relative to mental age and amount of instruction received.

REALITY PRINCIPLE: In Freudian theory, the concept that the *Pleasure principle* (q.v.) in personality development in infancy is normally modified by the inescapable demands and requirements of external reality. The process by which this compromise is effected is technically known as "reality testing," occurring both in normal growth and in psychiatric treatment.

RECALL: The process whereby a representation of past experience is elicited; the repetition of words or similar material previously learned.

RECEPTIVE CHARACTER: A person who requires support from other persons, is passive in relation to them, and finds gratification in what is given to him.

RECIDIVISM: The repetition or recurrence of delinquent or criminal conduct, or of a mental disorder.

REFERENCE, DELUSION OF, or IDEA OF: See *Ideas of reference*.

REFLEX: A very simple act in which there is no element of choice or premeditation and no variability save in intensity or time.

REGRESSION: The readoption, partially or symbolically, of more infantile ways of gratification. Most clearly seen in severe psychoses.

REHABILITATION: Restoration to a satisfactory physical, mental, vocational, or social status after injury or illness, including mental illness. The status need not be the same as that preceding the injury or illness. Rehabilitation may be concurrent with, and may play a part in, physical or psychological therapy.

REJECTION: The process or the fact of regarding something as worthless, of throwing it away, or of refusing to admit it to a certain category. In interpersonal relations rejection is seldom absolute and usually manifests itself in indirect ways.

REJUVENATION: The restoration of a person to youthfulness. A number of surgical and mental procedures have been tried as modern equivalents of the "fountain of youth."

REMISSION: Abatement of an illness.

REPETITION COMPULSION: In psychoanalytic theory the impulse to reenact earlier emotional experiences. Considered by Freud more fundamental than the *Pleasure principle* (q.v.). According to Ernest Jones: "The blind impulse to repeat earlier experiences and situations quite irrespective of any advantage that doing so might bring from a pleasure-pain point of view."

REPRESSION: A mental mechanism, operating unconsciously. The common denominator and unconscious precursor of all mental mechanisms in which there is involuntary relegation of unbearable ideas and impulses into the unconscious, whence they are not ordinarily subject to voluntary recall but may emerge in disguised form through utilization of one of the various mental mechanisms. Repression is particularly operative in early years. See *Mental mechanisms*.

RESERPINE: A hypotensive alkaloid obtained from *Rauwolfia* (q.v.), used in arterial hypertension and as a sedative in psychotic states.

RESIDENTIAL TREATMENT: A term denoting psychiatric treatment in an institution, in contradistinction to outpatient treatment.

RESISTANCE: In psychiatry, an individual's massive psychologic defense against bringing repressed (unconscious) thoughts or impulses into awareness, thus avoiding anxiety.

RESTRAINT: A measure in the treatment of the violently psychotic patient whereby he is prevented by physical bonds (camisole or straitjacket) from injuring himself or others.

RETARDATION: Slowing down of mental and physical activity. Most frequently seen in severe depressions which are sometimes spoken of as retarded depressions. Also a synonym for *Mental deficiency* (q.v.).

RETROGRADE AMNESIA: See *Amnesia*.

RETROSPECTIVE FALSIFICATION: Unconscious distortion of past experiences to conform to present emotional needs.

RIGIDITY: In psychiatry, refers to an individual's great resistance to change.

RITUAL: In psychiatry, the senseless, repeated behaviors (other than tics) that are part of obsessive-compulsive neurosis. Any stereotyped behavior that is not directly adjustive but protects (or seems to protect) the individual against internal conflict.

ROLE: The function played by an individual in a group; the individual's characteristic kind of contribution to a group. The behavior that is characteristic and expected of the occupant of a defined position in a group.

ROLE-PLAYING: Acting according to a role that is not one's own. In psychotherapy, role-playing is used in a variety of ways: to discover how the client conceives of certain important social roles and how he believes he functions in them, to help the individual gain insight into the conduct of others, and in play therapy to effect a catharsis. Role-playing is also used as an educational device, e.g., in leadership training.

RORSCHACH TEST: A psychologic test developed by the Swiss psychiatrist, Hermann Rorschach (1884-1922), that seeks to disclose conscious and unconscious personality traits and emotional conflicts through eliciting the patient's associations to a standard set of inkblots.

ROTE LEARNING: Memorizing in which the task as seen by the learner requires no understanding but merely the reproduction of words or other symbols in the exact form in which they were presented.

SADISM: Pleasure derived from inflicting physical or psychologic pain on others. The sexual significance of sadistic wishes or behavior may be conscious or unconscious. The reverse of *Masochism* (q.v.).

SADOMASOCHISM: The tendency to both sadism and masochism.

SANITY: A prescientific term for the normal mental condition of the human individual. Antonym: *Insanity* (q.v.).

SATYRIASIS: Pathologic or exaggerated sexual drive or excitement in the male. May be of psychic or organic etiology. Analogous to *Nymphomania* (q.v.) in the female.

SCAPEGOAT: Any person or group that becomes the object of displaced aggression. The scapegoat is blamed for frustrations and disappointments having other origins. See *Displacement*.

SCHISTOSOMIASIS: Infestation with a species of bloodfluke (parasitic worm).

SCHIZOID: Adjective describing traits of shyness, introspection, and introversion.

SCHIZOPHRENIA: A severe emotional disorder of psychotic depth characteristically marked by a retreat from reality with delusion formations, hallucinations, emotional disharmony, and regressive behavior. Formerly called *Dementia praecox*. Some types of schizophrenia are distinguished as follows:

CATATONIC TYPE: Characterized by marked disturbances in activity, with either generalized inhibition or excessive activity. See *Catatonia*.

HEBEPHRENIC TYPE: Characterized by shallow, inappropriate emotions and unpredictable and childish behavior and mannerisms.

LATENT TYPE: A preexisting susceptibility for developing overt schizophrenia under strong emotional stress or deprivation.

PARANOID TYPE: Characterized predominantly by delusions of persecution and/or *Megalomania* (q.v.). See also *Delusion*.

SIMPLE TYPE: Characterized by withdrawal, apathy, indifference, and impoverishment of human relationships, but rarely by conspicuous *delusions* or *hallucinations*. It is slowly and insidiously progressive and tends to be unresponsive to current treatments.

Some less common types are:

CHILDHOOD SCHIZOPHRENIA: The somewhat rare onset of schizophrenic reactions in childhood.

PSEUDONEUROTIC TYPE: A form of schizophrenia in which the underlying psychotic process is masked by complaints ordinarily regarded as neurotic.

SCHIZO-AFFECTIVE TYPE: Cases in this category show significant admixtures of schizophrenic and affective (manic-depressive) reactions.

- SCOPOLAMINE:** An alkaloid used in combination with morphine to produce partial anesthesia (twilight sleep) in obstetrics.
- SCOTOMA:** In psychiatry, a figurative blind spot in an individual's psychologic awareness.
- SCREEN MEMORY:** A consciously tolerable memory that unwittingly serves as a cover or "screen" for another associated memory which would be disturbing and emotionally painful if recalled.
- SECLUSIVENESS:** The tendency to cut oneself off from human contacts.
- SECONDARY GAIN:** The external gain which is derived from any illness (e.g., personal attention and service, or monetary gains such as disability benefits). See *Primary gain*.
- SECURITY:** A state in which satisfaction of needs and desires is guaranteed, either without effort or, more often, with reasonable striving. A complex attitude of self-possession and self-confidence in belonging to valued social groups.
- SEDUCTION:** Inducing another person, without force or threat, into unlawful sexual relations.
- SELF:** Used in many combining forms to denote the individual person, the living being; or as a specific part or aspect of that being; or as the individual as revealed or known to himself.
- SELF-ABASEMENT:** Extreme submission or yielding to another, together with strong feelings of inferiority.
- SELF-ACCUSATION:** Blaming oneself, usually falsely or to an unwarranted degree.
- SELF-ALIENATION:** A state in which the person feels that his self is unreal.
- SELF-AWARENESS:** Knowledge of one's own traits or qualities; insight into, and understanding of, one's own behavior and motives.
- SELF-DECEPTION:** Failure (partially unwittingly) to recognize the true state of affairs in something that closely concerns oneself.
- SELF-DENIAL:** Deliberate forgoing of satisfactions.
- SELF-EFFACEMENT:** A major neurotic solution of inner conflicts, characterized by identification with the despised self and subsequent unconscious idealization of dependency and compliancy.

SELF-ESTEEM: Psychodynamically, a state of being on good terms with one's *Superego* (q.v.). Pathologic loss of self-esteem is characteristic of depression.

SELF-IDEALIZATION: The process by which an almost impossible idealization of what one ought to be—the perfected and glorified self—is developed and maintained.

SELF-IMAGE: The image one has of oneself. This is a complex concept of one's personality, character, status, bodily appearance, etc., which may differ greatly from objective fact.

SELF-PUNISHMENT: See *Masochism*.

SEMEIOLOGY: The systematic study of the signs of specific diseases; the branch of medical science dealing with symptoms of diseases.

SEMEIOLOGIST: A specialist in semeiology.

SENESCENCE: The period in which one becomes old, or is old.

SENILE DEMENTIA: See *Dementia, senile*.

SENILE PSYCHOSIS: A mental illness of old age characterized by personality deterioration, progressive loss of memory, eccentricity, and irritability. Sometimes called senile dementia. See *Dementia, senile*.

SENILITY: Loss of mental, or mental and physical, functions in old age.

SENIUM: Medical term for old age.

SENSORIUM: Roughly approximates consciousness. Includes the special sensory perceptive powers and their central correlation and integration in the brain. A clear sensorium conveys the presence of a reasonably accurate memory together with a correct orientation for time, place, and person.

SEPARATION ANXIETY: (psychoanalytic term) The infant's fear of losing the mother object; hence, such anxiety based on early experience.

SEX: Either of the two categories of organisms, female or male, based on the distinction of producing, respectively, egg cells or sperm cells; the sum of the characters, especially the physical ones, that makes the male and female different; the behavior domain closely related to the organs of reproduction.

SEX DELINQUENCY (SEX CRIME): Any violation of established legal or moral codes in respect to sexual behavior.

SEX EDUCATION: Any educative process designed to help the individual to healthy and/or socially approved sexual adjustment and constructive sexual expression.

SEXUAL ABSTINENCE: Act or process of refraining from sexual activity.

SEXUAL DEVIATION: Sexual behavior at variance with more or less culturally accepted sexual activities. Includes *Homosexuality* (q.v.), *Transvestism* (q.v.), sexual *Sadism* (q.v.), and sexually violent (criminal) acts.

SEXUAL SYMBOL: See *Symbolization*.

SHELL SHOCK: Obsolete, nonspecific term used in World War I to include a variety of emotional disorders of a neurotic type. These were predominantly somatic conversion (hysterical) reactions in situations of wartime stress. See *Conversion*.

SHOCK TREATMENT: A psychiatric therapy in which electric current, insulin, carbon dioxide, or metrazol are administered to the patient and result in a convulsive or comatose reaction intended to alter the course of the illness favorably. Some common types of shock treatment are:

CONVULSIVE SHOCK TREATMENT: Usually carried out by stimulation with an electric current, and hence called electroshock treatment (*E.S.T.* or *E.C.T.*). Often used in depressive reactions and most effective in this form of illness.

Modifications are: *Electronarcosis*, producing narcotic-like states, and *Electrostimulation*, which avoids convulsions.

INSULIN COMA TREATMENT: Insulin is administered in large enough doses to produce a hypoglycemic (low blood sugar) reaction resulting in a "deep" coma. Usually employed in treating schizophrenic reactions in a hospital setting.

SUBCOMA INSULIN TREATMENT: A form of treatment in which drowsiness or somnolence (short of coma) is produced.

SIBLING RIVALRY: Rivalry between sibs, i.e., offspring of either sex from the same mother or the same father; often a cover for jealous desire to usurp a sib's place in the parents' affection.

SITUATIONAL DEPRESSION: See *Reactive depression* under *Neuroses; Depression*.

SLEEPWALKING: See *Somnambulism*.

SOCIAL: Of, or pertaining to, society as a group of interdependent and interrelated persons; used in phrases (as social adjustment) when the social aspect of the key word is to be emphasized.

SOCIAL WORK: The use of community resources and of the conscious adaptive capacities of individuals and groups to better the adjustment of an individual to his environment, or of the environment to the individual.

SOCIAL WORKER, PSYCHIATRIC: A social worker with a master's degree in social work who utilizes social work techniques in a psychiatric (medical) setting.

SOCIOMETRY: The quantitative study of what members of a group perceive, think, and feel about the other members; by extension, the quantitative study of various aspects of group relationships.

SOCIOPATHIC PERSONALITY: A broad category for disorders in one's relationship with society and with the cultural milieu.

SODOMY: Anal intercourse between males. Legally, the term may include other types of perversion.

SOMATIC CONVERSION: See *Conversion hysteria* under *Neuroses*.

SOMATIZATION REACTION: See *Conversion hysteria* under *Neuroses*.

SOMATOPSYCHIC: Pertaining to both body and mind (or emotions).

SOMATOTYPE: See *Body type*.

SOMESTHETIC: Pertaining to the sense yielding direct impression of the bodily condition, in contrast to that from the special senses of sight, hearing, etc.

SOMNAMBULISM: Sleepwalking. Also applied to some states of deep hypnosis.

SPASM: Localized, energetic, involuntary muscular contraction.

SPASTICITY: Heightened resistance to flexion or extension of a joint, attributed to a lesion in the central nervous system.

SPEECH DISORDER: Any long-term disorder in speaking or in perception of speech, so grave as to interfere seriously with communication.

SPINAL CORD: The long thick cord of nerve tissue that extends along the back, enclosed in the spinal canal.

SPIRITUALISM: A cult or religious belief in the activities of spirits in the affairs of this world.

SPLIT PERSONALITY: See *Personality, multiple*. In distinction to multiple personality, split personality denotes that individual psychic functions are split off from the personality as a whole.

STANFORD-BINET SCALE: A series of tests for the measurement of intelligence in schoolchildren; a revision of the original Binet-Simon Scale made in 1916 to fit American conditions, and further revised in 1937.

STATUS EPILEPTICUS: More or less continuous epileptic seizures.
See *Epilepsy*.

STEREOTYPY: Persistent, mechanical repetition of an activity, common in schizophrenia.

STERILITY: Inability to serve as one partner in the union of mature germ cells to start a new life; the inability may be due to physical or psychological causes.

STIGMATA: Certain markings, supposedly of supernatural origin, impressed on the bodies of saints, e.g., marks resembling the wounds of Christ.

STRABISMUS: State of being cross-eyed.

STRAITJACKET: A coat of strong material binding the body, for restraining violent mental patients.

STRESS: A force, physical or psychological, applied to a system, physical or psychological, sufficient to cause strain or distortion, or to alter the system into a new form.

STRESS REACTION: See *Acute situational or stress reaction*.

STUPOR: In psychiatry, a state in which the individual appears to be unaware of, and nonreactive to, his surroundings. In catatonic stupor, however, it is believed the unawareness is more apparent than real. See *Catatonía*.

STUTTERING AND STAMMERING: Spasmodic speaking with involuntary halts and repetitions, usually considered of psychogenic origin.

SUBCONSCIOUS: Psychiatrically obsolescent. Refers in general to both that which is not subject to recall and to that which may, with independent effort, be recalled.

SUBLIMATION: A mental mechanism, operating unconsciously, through which consciously unacceptable instinctual drives are diverted into personally and socially acceptable channels.

SUBMISSIVENESS: A personal trait leading one to accept the domination of others.

SUBSHOCK INSULIN TREATMENT: See *Subcoma insulin treatment* under *Shock treatment*.

SUBSTITUTION: A mental mechanism, operating unconsciously, by which an unattainable or unacceptable goal, emotion, or object is replaced by one which is more attainable or acceptable. Comparable to *Displacement* (q.v.).

SUGGESTIBILITY: The hypothetical general trait of being susceptible to suggestion.

SUPEREGO: In Freudian theory, that part of the mind which has unconsciously identified itself with important and esteemed persons from early life, particularly parents. The supposed or actual wishes of these significant persons are taken over as part of one's own personal standards to help form the "conscience." They may remain anachronistic and overpunitive, especially in psychoneurotic patients. See also *Ego*; *Id*.

SUPPORTIVE THERAPY: A form of psychotherapy in which the therapist gives direct help and provides encouragement. See *Psychotherapy*.

SUPPRESSION: Conscious effort to overcome unacceptable thoughts or desires. See *Repression*.

SURROGATE: A substitute person. In psychiatry, usually refers to an authoritarian person (parental).

SYMBIOSIS: Any close, mutual-aid relationship between individuals, as within the family.

SYMBOLIZATION: A mental mechanism, operating unconsciously, in which a person forms an abstract representation of a particular object, idea, or constellation thereof. The symbol carries in more or less disguised form the emotional feelings vested in the initial object or ideas.

SYMPATHIN: A hormone similar to adrenalin in action.

SYMPATHOMIMETIC: Denoting simulation of sympathetic nerve action.

SYMPATHY: Expression of compassion for another's grief or loss. To be differentiated from *Empathy* (q.v.).

SYMPTOM: A specific manifestation of an illness, objective, subjective, or both.

SYMPTOMATOLOGY: The science of the symptoms of disease, their production, and the indications they present.

SYNAPSE: The region, or locus of points, at which a nervous impulse passes from the axon of one neuron to the dendrite or to the cell body of another. See *Neuron*.

SYNDROME: A group of symptoms which often indicate a recognizable illness.

TABOO: A solemn social prohibition of act or word, usually with irrational support and rather drastic penalties.

TALION LAW OR PRINCIPLE: In the Bible, "an eye for an eye" or "a tooth for a tooth." In psychiatry, the primitive, unrealistic belief, often unconscious, that hostile thoughts or words inevitably lead to retaliation in kind.

TANTRUM: An uncontrolled display of anger and ill temper, with crying, kicking, screaming, etc.

TELEPATHY: The communication of thoughts from one person to another without the intervention of physical means. Not yet generally accepted as scientifically valid. See also *Extrasensory perception*.

TEMPERAMENT: The susceptibility of the person to emotive situations; the tendency to experience changes in mood.

TEMPER TANTRUM: See *Tantrum*.

TEMPORAL LOBE: One of the five main divisions of the *Cerebrum* (q.v.) underlying the temples.

TENSION: A condition of the organism marked by unrest or uneasiness, by partly restrained restless activity, by pressure to act and readiness to act but with no implication of directed action. An emotional state resulting when needs are unsatisfied or goal-directed behavior is blocked.

TEST, PSYCHOLOGICAL OR MENTAL: A set of standardized or controlled occasions for response presented to an individual to elicit a representative sample of his behavior in specified areas.

THANATO: Combining form meaning death, as in *thanatophobia*: fear of death.

THEMATIC APPERCEPTION TEST (T.A.T.): A projective test in which a person is asked to tell a story suggested by each of nineteen pictures. The test assumes that the themes apperceived by the testee are those which are important in his own life. See *Projective test*.

THERAPIST: One skilled in the employment of treatment techniques.

THERAPY: Treatment intended to cure or alleviate a disordered condition, so that normal functioning is brought about. Used in various self-explanatory combinations.

THREAT: Verbal, gestural, or other symbolic expression of intent to injure or inflict evil on a person. A sign of evil or injury to come, inducing fear or anxiety. An imagined event, believed likely to happen, that excites dread.

THROMBOPHLEBITIS: Thrombosis with secondary inflammation of a vein.

THROMBOSIS: The formation of a blood clot within the heart or blood vessels.

- THUMB-SUCKING:** The earliest and one of the most common manipulations of the body found in infants and young children. If continued beyond early childhood (variously designated) it is classified as a neurotic trait.
- THYROID GLAND:** An endocrine gland whose lobes lie on either side of the upper windpipe. Its secretions are important in growth and in the control of metabolic rate. See *Gland*.
- TIC:** An intermittent, involuntary, spasmodic movement such as a muscular twitch. A tic may be a disguised expression of a hidden emotional conflict, or due to organic causes.
- TISSUE:** Any structure in an organism made up of similar elements or cells that perform a common function.
- TOILET TRAINING:** Teaching the infant the proprieties of his culture in regard to urination and defecation. Severity in toilet training is supposed to have devastating effects on the child's development.
- TOPECTOMY:** A type of *Psychosurgery* (q.v.).
- TORTICOLLIS:** Spasmodic contractions of the muscles of the neck. Called *Mental torticollis* when psychically determined.
- TOTAL PERSONALITY:** An individual's personality conceived of as a collection of all his traits.
- TOTAL PUSH THERAPY:** In a hospital setting, the energetic simultaneous application of all available psychiatric therapies to the treatment of a patient, first described by Abraham Myerson (1881–1948).
- TOXIC:** Pertaining to, or caused by, poison; poisonous.
- TOXIC PSYCHOSIS:** A psychosis resulting from the toxic effect of chemicals and drugs, including those produced in the body. See also *Psychosis*.
- TOXOPLASMOSIS:** Infection with a parasite which can cause hydrocephalus or microcephaly in the newborn, or mental retardation or encephalitis in children.
- TRANCE:** A sleeplike state marked by reduced sensitivity to stimuli, loss or alteration of knowledge of what is happening; substitution of automatic for voluntary activity. Trances are frequent in hysteria, and they may be hypnotically induced.

TRANQUILIZING DRUG: Used in inducing *Ataraxy* (q.v.).

TRANSCERENCE: The unconscious attachment to others of feelings and attitudes which were originally associated with important figures (parents, siblings, etc.) in one's early life. The transference relationship follows roughly the pattern of its prototype. The psychiatrist utilizes the phenomenon as a therapeutic tool to help the patient understand his emotional problems and their origin. In the patient-physician relationship the transference may be negative (hostile) or positive (affectionate). See also *Countertransference*.

TRANSORBITAL LOBOTOMY: A type of *Psychosurgery* (q.v.).

TRANVESTISM: Sexual pleasure derived from dressing or masquerading in the clothing of the opposite sex. The sexual origins of transvestism may be unconscious. Also spelled *Transvestitism*.

TRAUMA: Psychological or physical injury.

TRAUMATIC NEUROSIS: A neurosis precipitated by a trauma, either somatic or psychic, in which the symptoms are closely related to the original trauma.

TREATMENT: Any measure designed to ameliorate or cure an abnormal or undesirable condition.

TREMOR: Shaking or trembling. A disorder in which the usual normal contractions of a muscle become exaggerated to the point of awareness.

TRIODIONE: Anticonvulsant drug used in the treatment of petit mal and other types of epilepsy.

TUBERCULAR PERSONALITY: Term denoting the mental and psychic characteristics of tubercular patients.

TUMOR: A swelling or new growth having no physiological function.

TWILIGHT SLEEP: A condition of partial anesthesia or subconsciousness which dulls awareness to pain and softens or effaces memory.

TWILIGHT STATE: A transitory disturbance of consciousness during which many acts may be performed without conscious volition and without retention of any remembrance of them.

TWIN: One of two mammals gestated in the same uterus at the same time. In human beings there are two distinct types of twins: identical (monozygotic), developed from a single egg, and fraternal (dizygotic), developed from two eggs.

TWIN STUDIES: A method used in psychiatric genetics for differentiation between genetic and environmental influences in relation to specific forms of adjustment or maladjustment; the dissimilarities of identical twins are compared with those of fraternal twins or siblings.

TYOLOGY: The study of types. A particular system for the classification of types.

ULCER: An open sore on the skin or mucous membrane that discharges pus.

UNCONSCIOUS: In Freudian theory, that part of the mind or mental functioning the content of which is only rarely subject to awareness. It is a repository for data which have never been conscious (primary repression), or which may have become conscious briefly and were then repressed (secondary repression).

UNDERACHIEVER: A person who does not perform in specific ways as well as expected from certain known characteristics or previous record; specifically, a student who does not accomplish as much in school as would be expected from his measured intelligence.

UNDERSTANDING: The process of apprehending or grasping a meaning. Sympathy resulting from considering a person's behavior from his standpoint. Understanding is said to consider not cause-and-effect relations, but the inner significance of a psychic process.

UNDOING: A primitive defense mechanism, operating unconsciously, in which something unacceptable and already done is symbolically acted out in reverse, usually repetitiously, in the hope of "undoing" it and thus relieving anxiety.

UTERUS: The saclike structure in which the embryo of mammals develops within the mother's body.

VAGINA: The canal from the uterus to the exterior of the body.

VAGINISMUS: Painful vaginal spasm, usually occurring in connection with sexual intercourse.

- VEGETATIVE NERVOUS SYSTEM:** An incorrect synonym for *Autonomic nervous system* (q.v.).
- VERBIGERATION:** Stereotyped and seemingly meaningless verbal responses without relevance to the specific statement or question of another.
- VERBOSITY:** Use of more words than are necessary; may be of organic or psychic origin.
- VERTIGO:** Dizziness. This may be organically or psychiatrically determined. It is a frequent phenomenon in psychiatric patients.
- VIRUS:** A term for a group of disease-producing organisms which are barely visible or invisible under an ordinary microscope.
- VISCERAL IMPULSES:** Internal bodily processes, especially those caused by emotions.
- VISIONS:** Things "seen" other than by ordinary sight: imaginary, supernatural, or prophetic sights beheld in sleep or ecstasy.
- VOCATIONAL GUIDANCE:** See *Guidance*.
- VOLUNTARY HOSPITALIZATION:** A term denoting voluntary admission to a mental hospital, in distinction to *Commitment* (q.v.).
- VOODOO:** Belief in, or practice of, a primitive religion consisting largely of sorcery.
- VOYEURISM:** Sexually motivated and often compulsive interest in watching or looking at others, particularly at genitals. Roughly synonymous with "peeping Tom." Observed predominantly in males.
- WEANING, PSYCHOLOGICAL:** Breaking a child's ties of psychological dependence upon a parent.
- WECHSLER-BELLEVUE SCALE:** A test battery for intelligence, standardized for adults but usable for adolescents and older children.
- WET DREAMS:** Loss of semen during sleep. See *Nocturnal emission*.

WISH FULFILLMENT: The discharge of a tension by imagining a satisfying or tension-reducing situation; loosely, any indirect satisfaction, especially one that is accepted after frustration.

WITHDRAWAL: A pattern of action, induced by persistent frustration, in which a person removes himself from the realm of conflict and obtains satisfaction in such ways as daydreaming, drowsiness, alcoholism, etc., or escape into work where personal problems can be forgotten.

WORD SALAD: A mixture of words and phrases which lack comprehensive meaning or logical coherence, commonly seen in schizophrenic states.

WORRY: The emotional attitude characterized by uncertainty of one's ability to prevent the occurrence of an unsatisfactory state of affairs.

WRY NECK: See *Torticollis*.

ZOOPHILIA: Unusually strong attraction to animals.

NAME INDEX

- Abraham, Karl, 2: 640, 641; 4: 1339; 5: 1574, 1593
Ackerman, Nathan W., 2: 612-23
Adair, John, 6: 1902
Addison, Joseph, 4: 1469
Adler, Alfred, 2: 445, 640; 4: 1431, 1469; 5: 1574, 1577, 1592, 1593, 1601, 1734
Adler, H. M., 5: 1639
Adlerstein, Arthur M., 2: 435
Adorno, T. W., 5: 1526, 1552
Albee, George W., 1: 258-75; 5: 1624
Albright, Fuller, 3: 771
Alexander, Franz, 1: 127; 2: 641, 655; 5: 1574, 1575, 1576, 1593, 1713, 1714; 6: 1980
Alexander, Irving E., 2: 435
Allen, E. B., 1: 134
Allport, Gordon, 2: 436, 679, 687; 4: 1467, 1470, 1473, 1484; 5: 1546
Altschul, R., 4: 1335
Alvarez, W., 4: 1339
Anatruda, Catherine S., 1: 107
Amiens, Bishop of, 2: 684
Anglicus, Bartholomaeus, 3: 739
Angval, A., 4: 1473
Anthony, Daniel S., 2: 692
Anthony, Sylvia, 2: 441
Appel, Kenneth E., 5: 1567-85
Aquinas, Thomas, 2: 661
Argyris, Chris, 6: 2012
Aristotle, 2: 684; 3: 794; 4: 1233, 1336, 1425
Arlow, Jacob A., 2: 632-42
Arnold, Magda B., 2: 547-57
Aronson, Gerald J., 2: 443
Ashby, William R., 1: 329
Auden, W. H., 2: 632
Augustine, St., 3: 763
Auld, Frank, Jr., 3: 930-49
Austin, J. L., 1: 331
Avicenna, 3: 738
- Babinski, J., 4: 1344
Bacon, Francis, 5: 1620
Bailey, Pearce, 4: 1214
Baillarger, J. P., 4: 1418
Bakan, David, 5: 1758
Baldo, Camillo, 2: 684
Baldwin, Alfred Lee, 4: 1446
Baldwin, James M., 4: 1472, 1473
Baldwin, Joseph V., 1: 107
Balfour, Arthur J., 4: 1426, 1428
Balfour, Gerald W., 4: 1426
Balzac, Honoré de, 2: 684
Banay, Ralph S., 5: 1634-53
Bard, Morton, 4: 1495, 1496
Barker, Roger G., 5: 1506-8
Barrett, William F., 4: 1426, 1428
Barron, Frank, 2: 396-401, 661-6
Barrow, R. L., 2: 577
Basescu, Sabert, 2: 583-95
Basowitz, Harold, 6: 1977
Bateson, Gregory, 1: 325, 327, 333; 2: 417; 4: 1335; 6: 1900, 1901
Bazelton, David L., 2: 481, 513; 3: 911, 912
Beach, Frank, 3: 770, 1027
Beaglehole, Ernest, 2: 417
Bechterev, V. M., 5: 1621
Beers, Clifford W., 3: 1091, 1092, 1093, 1096, 1099, 1101; 4: 1106, 1286; 5: 1575; 6: 2060
Bell, Charles, 5: 1620
Bell, Norman W., 2: 596-611; 3: 968
Bender, Lauretta, 5: 1644, 1649, 1794
Benedek, Therese F., 3: 1027, 1029
Benedict, Ruth, 2: 417; 4: 1478; 6: 1897, 1903
Bennett, James V., 2: 368
Berblinger, Klaus W., 5: 1782-98
Berdvayev, Nikolai, 2: 585
Bergson, Henri, 3: 786; 4: 1426, 1428
Berkeley, George, 4: 1233; 5: 1620
Bernard, Claude, 4: 1260
Bernard, Jessie, 2: 487
Bernard, Viola W., 1: 70-108; 2: 481
Berne, Eric L., 2: 515-20
Bernheim, Hippolyte, 3: 741, 803; 4: 1344; 5: 1573, 1591; 6: 2001
Bernreuter, Robert G., 5: 1609
Bertocci, Peter A., 4: 1231-4, 1472
Bettelheim, Bruno, 5: 1527
Bierer, Joshua, 2: 710
Biggs, John, Jr., 2: 912
Billings, Josh. *See* Shaw, Henry W.
Binet, Alfred, 2: 693; 3: 884, 933; 5: 1606, 1608, 1621
Binger, Carl A. L., 2: 533-46
Bingham, Walter V., 1: 221
Bini, L., 5: 1676
Binswanger, Ludwig, 2: 588; 5: 1667
Bion, W. R., 6: 1996
Birdwhistell, R. L., 1: 327
Birren, James E., 1: 154
Blain, Daniel, 4: 1122-45, 1166-79

- Blanton, Smiley, 3: 1081
 Bleuler, Eugen, 2: 640; 5: 1574, 1670, 1783, 1784, 1785, 1786
 Blood, Robert O., Jr., 3: 976
 Bluemel, C. S., 5: 1523
 Boas, Franz, 6: 1897, 1898
 Boisen, Anton, 4: 1450, 1455; 5: 1753
 Bonaparte, Marie, 2: 642
 Bond, Earl D., 3: 1101; 5: 1574
 Boring, E. G., 5: 1620
 Boss, Medard, 2: 593, 598; 5: 1667
 Bottome, Phyllis, 2: 445
 Bourne, A., 4: 1341
 Bovet, L., 5: 1637, 1644
 Bowlby, John, 1: 75; 2: 609; 4: 1341, 1439; 6: 1911
 Bowman, Henry A., 3: 969
 Boyd, William, 1: 133
 Braatoy, Trygve, 1: 333
 Braceland, Francis J., 3: 850-58
 Brady, J. V., 1: 328
 Braid, James, 3: 803, 804
 Brenman, Margaret, 3: 816
 Brentano, Franz, 5: 1621
 Bress, David G., 2: 481
 Breuer, Josef, 2: 633, 634; 3: 803, 824; 5: 1591, 1729
 Briggs, L. Vernon, 3: 926
 Brill, Abraham A., 2: 640, 641; 3: 712; 5: 1574
 Brill, Henry, 5: 1722-7
 Broad, C. D., 4: 1428
 Broca, Paul, 2: 680
 Bromberg, Walter, 2: 429; 3: 737-65; 5: 1641, 1848-57
 Bronfenbrenner, Urie, 4: 1437-48
 Bronner, Augusta, 3: 1095
 Brosin, Henry, 1: 321-35
 Bruch, Hilde, 4: 1380
 Brücke, Ernst Wilhelm von, 2: 632, 633
 Bruner, Jerome S., 5: 1552
 Buber, Martin, 2: 585; 4: 1340
 Buchenholz, Bruce, 4: 1363
 Buell, Bradley, 2: 605
 Bullitt, William, 2: 642
 Bunzel, Bessie, 6: 1986
 Bunzel, Ruth, 2: 417
 Burrell, R. J. W., 2: 447
 Burt, C., 4: 1472
 Burton, Robert, 3: 740
 Busse, Ewald, 1: 168, 171; 5: 1829-36
 Butler, Nicholas Murray, 4: 1426
 Butler, Samuel, 4: 1469
 Butterfield, Oliver M., 3: 968
 Cabot, Richard, 4: 1450
 Calderone, Mary Steichen, 1: 14, 15, 26, 27
 Caligula, 4: 1418
 Calvin, John, 4: 1187
 Cambrai, Bishop of, 2: 684
 Cameron, Norman, 1: 13; 4: 1417
 Camp, Burton H., 4: 1426
 Camus, Albert, 1: 278
 Cannon, Walter, 2: 549; 5: 1571, 1713, 1787; 6: 1979
 Caplan, Gerald, 1: 336-54; 2: 521-32; 5: 1556-66
 Cardozo, Benjamin, 2: 411
 Carrington, Whately, 4: 1427
 Carstairs, Morris D., 6: 1902
 Carus, Paul, 6: 2001
 Cassirer, Ernst, 3: 759
 Castro, Fidel, 4: 1418
 Cato, 2: 429
 Cattell, R. B., 4: 1467, 1472, 1473; 5: 1621
 Caudill, William, 6: 1900, 1902
 Celsus, 3: 737
 Cerletti, U., 5: 1676
 Cermak, Anton J., 5: 1529
 Chaplin, Charles, 3: 786
 Charcot, Jean Martin, 1: 131; 3: 741, 823, 4: 1105, 1337; 5: 1573, 1591, 1594; 6: 2001
 Charlesworth, Dr., 3: 740
 Chaucer, Geoffrey, 4: 1169
 Chern, Isidor, 4: 1279, 1472
 Cherry, C., 1: 329
 Chesterfield, Earl of, 3: 790
 Christ, Adolph, 2: 439
 Christenson, C. V., 1: 27
 Christiansen, Harold, 2: 387, 395
 Churchill, Winston, 3: 877
 Cicero, 1: 136; 2: 439; 4: 1247, 1425
 Claparède, Edouard, 2: 518
 Clark, C. C., 4: 1429
 Clark, Kenneth, 5: 1624, 1632
 Clausen, John A., 2: 558-68; 4: 1444; 6: 1915-24, 1933-40
 Cleckley, Hervey M., 5: 1641; 6: 2001
 Clemmer, Donald, 2: 372
 Cloward, Richard, 3: 896
 Cobb, Stanley, 2: 681
 Cohen, Alfred K., 3: 896
 Cohen, Mabel Blake, 3: 958-64
 Cole, Jonathan O., 5: 1654-63
 Cole, Kathleen G., 5: 1654-63
 Collins, Mary E., 5: 1555
 Combs, A. W., 4: 1472
 Condillac, Étienne, 3: 740
 Conger, John J., 1: 29-36
 Conklin, Edmund, 5: 1645
 Conolly, John, 5: 1671
 Cornell, Julien D., 5: 1528
 Cowper, William, 6: 2017
 Cramer, M. Richard, 5: 1543-55
 Crépiaux-Jamin, J., 2: 684, 693
 Crookes, William, 4: 1426, 1428

- Cullen, William, 4: 1337; 5: 1670
 Currens, Donald Kenneth, 3: 912
 Daley, Sgt., 3: 788
 D'Andrade, Roy, 4: 1444
 Darwin, Charles, 2: 397, 633, 639; 5: 1581, 1588, 1591, 1620
 de Alvarez, Russell R., 6: 1968
 Delay, J., 5: 1655
 Dement, William C., 2: 498, 500
 Democritus, 4: 1233
 Denniker, P., 5: 1655
 Descartes, René, 2: 515
 Deutsch, Albert, 2: 473-82; 3: 776, 1098, 1101; 6: 1993
 Deutsch, Felix, 2: 641; 5: 1714
 Deutsch, Helene, 2: 643, 651, 654; 5: 1513; 6: 1868, 1967
 Deutsch, Morton, 5: 1555
 Devereux, E. C., 4: 1444
 Devereux, George, 6: 1900, 1902, 1905
 Devereux, Helena T., 4: 1189
 Dewey, John, 3: 939, 940; 4: 1472
 Diamond, Bernard L., 3: 908-29
 Dickens, Charles, 2: 684; 4: 1441; 6: 2014
 Dicks, Russell, 4: 1450
 Dix, Dorothea Lynde, 4: 1104; 5: 1575
 Dollard, John, 2: 418; 4: 1470; 5: 1551
 Dostoevski, Fedor, 2: 475; 4: 1469; 5: 1525, 1580
 Downey, June, 2: 687
 Drummond, Edward, 3: 909
 Dublin, Louis L., 6: 1986
 du Bois, C., 4: 1344
 Ducasse, C. J., 2: 438; 4: 1428
 Dudycha, George, 3: 1000
 Du Maurier, George, 3: 816
 Dunbar, Flanders, 5: 1575
 Dunham, H. Warren, 2: 565; 3: 1058; 4: 1340; 6: 1915
 Dupertuis, C. W., 2: 357
 Duvall, Evelyn, 2: 394; 3: 968
 Duvall, Sylvanus, 5: 1847
 Dyk, Ruth, 5: 1495, 1496
 Earle, Pliny, 4: 1105
 Eastman, Nicholson J., 1: 18
 Eaton, J. W., 5: 1540
 Ebaugh, Franklin, 5: 1645
 Ebbinghaus, Hermann, 5: 1620, 1621
 Eckert, Ralph G., 2: 381-95; 3: 969; 5: 1842-7
 Egas Moniz, A., 5: 1676, 1722
 Ehrenwald, Jan, 4: 1428
 Ehrman, Winston, 2: 385
 Einstein, Albert, 2: 396, 661
 Eisenberg, Leon, 1: 37-69
 Eisenbud, Jule, 4: 1428
 Eliot, George, 4: 1469
 Elkin, A. P., 4: 1434
 Ellenberger, Henri, 3: 744
 Ellis, Havelock, 2: 663, 665
 Emerson, Ralph Waldo, 2: 475; 5: 1580
 Engler, Richard, 1: 74
 Epicurus, 4: 1233
 Erikson, Erik H., 1: 75-6, 79, 280, 282, 292; 2: 417; 3: 865, 1083; 4: 1473; 5: 1518, 1521, 1593, 1685
 Esquirol, Jean E., 4: 1345; 5: 1638
 Eysenck, Hans J., 4: 1467, 1472; 5: 1524, 1621
 Fabing, H. D., 2: 577; 4: 1339
 Fairbairn, W. R., 4: 1339
 Faris, C., 4: 1340
 Faris, Robert E. L., 2: 565; 3: 1088; 6: 1915
 Farnsworth, Dana L., 3: 1080-90
 Fechner, G. T., 5: 1620
 Federn, Paul, 2: 516; 3: 742; 4: 1335
 Feifel, Herman, 2: 427-50
 Feld, S., 3: 1075
 Feldman, Harold, 4: 1438
 Feldman, Sandor, 1: 333
 Felix, Robert H., 2: 481; 4: 1107, 1292-1305
 Fenichel, Otto, 3: 758; 5: 1593
 Ferenczi, Sandor, 1: 333; 2: 640, 641; 3: 742; 5: 1574, 1593
 Fernald, Walter E., 4: 1189
 Feuchtersleben, Ernst von, 4: 1339; 5: 1670
 Finesinger, Jacob E., 3: 855
 Firth, Raymond, 6: 1898
 Fisher, Charles, 2: 498-514
 Fisher, R. A., 4: 1428
 Flandrin, Louis J. H., 2: 684
 Flexner, Abraham, 3: 1095
 Forkner, Claude, 2: 442
 Forstenzer, Hyman M., 4: 1103-21
 Fortes, Meyer, 6: 1898
 Foster, George, 6: 1902
 Foulkes, S. H., 2: 711; 6: 1996
 Fowler, William, 4: 1267-75
 Frank, Jerome D., 2: 707-15; 5: 1526, 1728-1736
 Frank, Lawrence K., 2: 417; 5: 1609
 Frankl, V. E., 4: 1344
 Franklin, Benjamin, 3: 802
 Frazer, James G., 6: 1897
 Freeman, Frank S., 3: 871-92
 Freeman, G. L., 6: 1980
 Freeman, Walter, 5: 1722
 French, John R. P., 6: 2028
 Freud, Anna, 1: 314; 3: 742, 865; 4: 1339; 5: 1520; 6: 1977
 Freud, Sigmund, 1: 126, 131, 176, 215, 258, 280, 291-2, 295, 332, 333; 2: 364, 446, 502-3, 504, 505, 506, 507, 509, 510, 516, 517, 518, 519, 535, 547, 593, 631, 632-42, 703;

Freud, Sigmund (*Cont.*)

3: 741, 742, 787, 789, 796, 797, 803, 820, 823, 824, 857, 864, 865, 866, 870, 953, 1002, 1040;
4: 1105, 1154, 1234, 1246, 1247, 1248, 1263, 1335, 1336, 1337, 1339-40, 1342, 1345, 1409, 1428, 1431, 1432, 1437, 1438, 1440, 1466, 1469, 1470, 1473, 1478, 1482, 1483; 5: 1487-1488, 1512, 1518, 1571, 1573, 1574, 1575-6, 1580, 1588-93, 1594, 1601, 1604, 1620, 1621, 1670, 1672, 1683, 1684, 1685, 1688, 1699, 1723, 1729, 1733, 1734, 1749, 1756, 1758, 1786, 1787, 1837, 1839, 1842, 1849; 6: 1977, 1978, 2000, 2001, 2002, 2004, 2005, 2029

Friedman, Arnold P., 2: 719-23

Friedman, Paul, 6: 1983-91

Frohlich, Moses M., 3: 1032-50

Fromm, Erich, 4: 1470; 5: 1574, 1593, 1734; 6: 2009

Fromm-Reichmann, Frieda, 1: 333; 2: 487; 4: 1470; 5: 1671, 1672

Froscher, Hazel B., 3: 973

Fry, Clements C., 3: 1081

Fulton, Robert L., 2: 436, 418

Funk, Casimir, 4: 1355

Funkenstein, Daniel H., 3: 1081

Galen, 3: 738; 4: 1324, 1336

Galileo, 2: 639

Galton, Francis, 2: 663, 697; 3: 877; 5: 1621; 6: 1970

Gandhi, Mohandas K., 5: 1580

Gantt, W. Horsley, 4: 1341; 5: 1575

Garrett, James F., 5: 1506, 1508

Gebhard, P. H., 1: 27

Gebtsattel, Viktor E. von, 2: 586

Georget, Etienne, 5: 1638

Gerard, Ralph W., 4: 1312-23

Gesell, Arnold, 1: 289; 5: 1611, 1630, 1631

Gianopoulos, Artie, 3: 970

Gibbon, Edward, 4: 1250

Gibbs, F. A., 2: 573

Gilbert, C. M., 5: 1524

Gill, Merton M., 3: 816

Gillin, J., 4: 1341, 1342

Ginzberg, Eli, 4: 1224, 1225

Gladstone, William F., 4: 1428

Glass, Albert J., 2: 435; 4: 1213-30

Glick, Paul, 2: 492

Glover, Edward, 3: 742

Gluckman, Max, 6: 1905

Glueck, Bernard, 5: 1639

Glueck, Eleanor, 2: 494; 3: 895, 897; 5: 1641
Glueck, Sheldon, 2: 494; 3: 895, 897; 5: 1641, 1647

Goethe, Johann Wolfgang von, 2: 444, 684; 4: 1425

Gogh, Vincent van, 5: 1674

Goldensohn, Eli S., 2: 569-82

Goldhamer, H., 6: 1908

Goldney, K. M., 4: 1427

Goldzieher-Roman, Klara, 2: 686

Golin, Milton, 3: 815

Gonick, M. R., 5: 1506

Goode, William J., 2: 485, 486, 495; 3: 974

Goodenough, Florence L., 4: 1473; 5: 1609

Goodwin, Hilda M., 2: 483-97; 3: 965-89

Gorer, Geoffrey, 2: 417

Gosney, E. S., 6: 1971

Gralnick, Alexander, 4: 1418

Greenblatt, Milton, 1: 328; 5: 1737-47

Greenwood, J. A., 4: 1428

Greville, T. N. E., 4: 1428

Grinker, Roy R., 1: 131; 2: 435; 4: 1335; 5: 1714; 6: 1977, 1981

Groddeck, Georg, 1: 333; 2: 641

Gross, Leonard, 5: 1759

Gruenberg, Sidonie, 5: 1815

Grünwald, Gerhard, 2: 699

Gubner, Richard S., 1: 132

Guilford, J. P., 4: 1472

Gundle, Sigmund, 3: 1084

Gurin, G., 3: 1075

Guthrie, E. R., 5: 1621

Guttentag, Otto E., 2: 427

Guttmacher, Alan F., 1: 18

Hackett, Thomas, 2: 447

Haddon, Alfred C., 6: 1897

Haigh, Gerard V., 1: 276-86

Hall, G. Stanley, 4: 1426, 1472, 1473; 5: 1621

Hall, Victor E., 2: 427

Hallowell, A. Irving, 2: 417

Harlow, H. F., 5: 1682, 1683

Harrower, Molly, 5: 1605-17

Hartl, E. M., 2: 357

Hartmann, Eduard von, 6: 2001

Hartmann, Heinz, 3: 865; 5: 1593

Hastings, James, 4: 1247

Hathaway, Starke R., 5: 1609

Hauptmann, A., 2: 570

Havemann, Ernest, 3: 834; 5: 1630

Hawthorne, Nathaniel, 1: 313

Hayakawa, S. I., 1: 331

Healy, William, 1: 314; 3: 1095; 4: 1106; 5: 1639

Heath, R. G., 4: 1335

Hebb, D. O., 1: 332; 2: 547; 5: 1673, 1837

Hegel, Georg, 4: 1233

Heidegger, Martin, 2: 585, 586; 5: 1667

Helmholtz, Hermann von, 2: 633; 5: 1620

Henderson, D. K., 5: 1639, 1643, 1647

Henry, George W., 3: 751

Henry, Jules, 6: 1902

Herbart, Johann F., 6: 2001

Herberg, Will, 5: 1748

Hersher, Leonard, 1: 287-302

- Herzberg, F., 6: 2029
 Hilgard, E. R., 4: 1472
 Hill, Reuben I., 3: 968
 Himwich, H., 4: 1339
 Hippocrates, 1: 227; 2: 570; 3: 737, 738; 4: 1168, 1324, 1336, 1337; 5: 1729
 Hitler, Adolf, 3: 952; 4: 1312, 1418; 5: 1524, 1526
 Hoagland, H., 4: 1335
 Hobbes, Thomas, 3: 740, 794; 4: 1233; 5: 1620
 Hockett, Charles F., 1: 327, 333
 Hocking, William E., 2: 430
 Hodgson, Richard, 4: 1426
 Hoff, Ebbe Curtis, 1: 179-204; 2: 451-9
 Hollingshead, August B., 2: 566; 3: 1061; 5: 1572, 1675; 6: 1915, 1923
 Holmes, Oliver Wendell, 1: 142; 6: 1971, 1974
 Holmes, Mrs. Oliver Wendell, 6: 1884
 Holzman, Philip S., 4: 1458-66
 Homburger, August, 1: 314
 Horace, 2: 430
 Horney, Karen, 2: 641; 3: 742; 4: 1340, 1470; 5: 1574, 1575, 1593, 1734
 Horsley, Victor A., 2: 570
 Houk, Ralph, 2: 683
 Hubbard, L. Ron., 1: 331
 Hudson, W. H., 2: 440
 Hug-Hellmuth, Hermine von, 1: 314
 Hughes, Charles C., 6: 1911
 Hull, Clark L., 2: 547; 4: 1105, 1470-71; 5: 1621
 Hume, David, 5: 1620
 Hunt, Robert C., 6: 1994
 Husserl, Edmund, 2: 585
 Huxley, Aldous, 1: 340
 Huxley, Thomas, 2: 396, 397; 3: 877
 Hyslop, James H., 4: 1426

 Ingersoll, Robert G., 2: 475
 Itard, J. E. M. Gaspard, 4: 1188

 Jackson, Don D., 6: 1901
 Jackson, Edgar N., 2: 437, 441
 Jackson, John Hughlings, 2: 570
 Jaffé, Aniela, 4: 1432
 Jahoda, Marie, 3: 1067-79
 James, William, 2: 438, 515; 3: 999, 1091; 4: 1105, 1423, 1426, 1428, 1472; 5: 1620
 Janet, Pierre, 4: 1105, 1139; 5: 1573, 1621
 Janis, Irving L., 5: 1496
 Jarrett, Mary C., 5: 1639
 Jaspers, Karl, 2: 585, 586
 Jefferson, Thomas, 2: 475; 5: 1581
 Jelliffe, Smith Ely, 2: 641; 5: 1574
 Jellinek, E. M., 1: 179
 Jenkins, Richard L., 1: 25

 Johnson, Gertrude, 4: 1427
 Johnson, Samuel, 4: 1469
 Johnson, Wendell, 6: 1952-61
 Johnstone, E. R., 4: 1189
 Jolliffe, Norman, 1: 31
 Jones, Ernest, 2: 640; 3: 742
 Jones, Georgeanna S., 3: 1029
 Jones, Maxwell, 6: 1912, 1992-9
 Jones, M. R., 4: 1266
 Jonson, Ben, 4: 1469
 Jung, Carl G., 2: 437, 593, 640, 699, 3: 742, 1002; 4: 1340, 1424, 1428, 1431, 1432, 1469, 1473; 5: 1574, 1592, 1593, 1620, 1734, 1758, 1601; 6: 2000

 Kahn, Alfred J., 3: 893-907
 Kahn, Eugen, 5: 1639
 Kallman, Franz, 4: 1335; 5: 1575, 1667
 Kalven, Harry, 6: 1974
 Kanner, Leo, 1: 314; 5: 1794
 Kant, Immanuel, 2: 515; 4: 1233, 1246, 1425
 Kardiner, Abram, 2: 417, 611; 3: 742; 5: 1550, 1593; 6: 1900, 1903
 Karon, Bertram, 5: 1550
 Karpf, Maurice, Jr., 3: 989
 Karpinos, Bernard, 4: 1225
 Karpman, Benjamin, 1: 170; 3: 747, 756, 764
 Karson, Marc, 6: 2042
 Kasper, August, 2: 445
 Kearns, H. M., 3: 1081
 Kennedy, John F., 4: 1190, 1203
 Kenworthy, Marion E., 2: 481; 4: 1106
 Kety, Seymour S., 1: 227-34; 2: 481; 5: 1763
 Kierkegaard, Søren, 2: 585; 4: 1340
 Kinsey, Alfred C., 1: 15, 26, 137, 139, 155, 171; 2: 384, 385, 392, 394, 477, 643, 644, 646, 648, 650, 652; 3: 835, 838, 839; 5: 1678, 1700, 1701, 1706, 1708, 1842, 1862; 6: 1873, 1879, 1965, 2071
 Kirkbride, T. S., 4: 1139
 Kirkendall, Lester, 2: 385, 386
 Klages, Ludwig, 2: 685, 686, 699
 Kleegman, Sophia, J., 1: 14
 Klein, Melanie, 1: 314; 2: 438; 4: 1339; 5: 1593, 1670
 Klein, Viola, 6: 2013
 Kleitman, Nathaniel, 2: 498
 Klineberg, Otto, 2: 418
 Klopfer, Bruno, 2: 418
 Kluckhohn, Clyde, 5: 1618; 6: 1900
 Koch, J. A. L., 5: 1638
 Koffka, K., 4: 1472
 Kohler, Wolfgang, 5: 1621
 Kohn, Melvin, 4: 1442, 1444; 6: 1925-32
 Kolb, Lawrence C., 4: 1415
 Koller, Carl, 2: 633
 Korchin, Sheldon J., 6: 1975-82
 Kornhauser, Arthur, 6: 2028

- Korzybski, Alfred, 1: 331; 3: 744
 Kraepelin, Emil, 2: 686; 3: 1039; 4: 1335;
 5: 1573, 1639, 1670, 1786, 1787
 Kraft, Alan M., 3: 1084
 Krapf, E. Eduardo, 6: 1907-14
 Kretschmer, Ernst, 2: 363, 364; 4: 1468, 1469;
 5: 1574, 1666
 Krich, Aron, 3: 968
 Kris, Ernst, 3: 865; 4: 1340; 5: 1593
 Kroeber, Alfred L., 6: 1897-1900
 Kropotkin, Petr, 2: 475
 Kubie, Lawrence S., 4: 1346-54
 Kuder, G. Frederic, 5: 1609
 Kuhlen, Raymond, 5: 1815
 Kurland, Leonard T., 2: 573
- La Barre, Weston, 1: 332
 La Bruyère, Jean de, 4: 1469
 Lambert, S. M., 2: 447
 Lander, Bernard, 3: 895
 Landis, Paul H., 2: 489
 Landy, David, 6: 1902
 Lane, Robert F., 5: 1530
 Lang, Andrew, 4: 1425, 1426
 Lange-Eichbaum, Wilhelm, 5: 1523
 Langer, Marion, 6: 2013-26
 Lao-tze, 2: 435
 Larkin, Jerome, 4: 1430
 Larrick, George P., 4: 1362
 Lasswell, Harold D., 5: 1523-30; 6: 2007-12
 Lavoisier, Antoine, 3: 803; 4: 1355
 Lawrence, D. H., 2: 640; 5: 1580
 Leake, Chauncey D., 5: 1495
 Lee, Beatrice, 5: 1815
 Lehmann, H. E., 2: 554
 Lehrman, Daniel S., 1: 205-11
 Leibnitz, Gottfried von, 4: 1233
 Leighton, Alexander H., 2: 568; 6: 1901,
 1902, 1905, 1911
 Lemkau, Paul V., 1: 136; 5: 1531-42; 6: 1997
 Lennox, W. G., 2: 570, 573, 574
 Levin, Max M., 5: 1760-68
 Levine, Jacob, 3: 786-99
 Levine, Lena, 3: 1011-31
 Levinson, Harry, 6: 2027-48
 Levy, David, 4: 1106, 1441
 Levy, John, 3: 968
 Lévy-Bruhl, Lucien, 4: 1425
 Lewin, Bertram, 4: 1478; 5: 1621, 1670
 Lewin, Kurt, 4: 1470; 6: 1980
 Lewinson, Thea S., 3: 687
 Liddell, H. S., 4: 1341
 Lidz, Theodore, 2: 600; 3: 818-26
 Liebeault, A. A., 3: 741, 803; 5: 1573; 6: 2001
 Lilly, J. C., 1: 332; 5: 1673
 Lima, L., 5: 1676
 Lincoln, Abraham, 2: 475; 5: 1581
- Lindemann, Erich, 2: 703-6, 716-18; 6: 2014
 Linden, Maurice, 1: 156, 165
 Lindner, Robert, 5: 1525
 Lindsey, Benjamin B., 6: 1872
 Linton, Ralph, 6: 1900, 1903
 Linzer, Edward, 4: 1286-91
 Locke, John, 4: 1233; 5: 1620
 Locock, Charles S., 2: 570
 Lodge, Oliver, 4: 1426, 1428
 Loewenstein, Rudolph, 4: 1340
 Loomis, Earl A., Jr., 5: 1718-59
 Lorenz, Konrad, 5: 1683
 Lourie, Reginald S., 1: 313-320
 Lowie, Robert H., 6: 1897
 Lundholm, H., 4: 1472
- McCann, Richard, 4: 1453
 McCarthy, Raymond G., 5: 1653
 Maccoby, Eleanor E., 3: 970
 M'Connell, David, 4: 1430
 McCord, Joan, 5: 1641, 1646
 McCord, William, 5: 1641, 1646
 McDermott, E., 2: 357
 McDevitt, John B., 2: 624, 31
 McDougall, William, 4: 1263, 1426, 1428; 5:
 1621
 McFarland, Ross, 1: 35
 McGinnis, Robert, 1: 37
 McGregor, Douglas, 6: 2033
 Mackay, R. P., 1: 329
 McKinley, J. Charnley, 5: 1609
 MacKinnon, Donald W., 4: 1467-84
 MacLay, W. S., 6: 1996
 MacRobert, Russell G., 4: 1429
 Magendie, François, 5: 1620
 Magoun, F. Alexander, 3: 968
 Mahler, Margaret S., 5: 1517, 1522
 Mailloux, Noel, 4: 1246, 1248
 Maimonides, 3: 738
 Main, Tom, 6: 1995, 1996
 Malinowski, Bronislaw K., 6: 1897, 1898
 Malmo, R. B., 1: 328
 Malthus, Thomas, 5: 1533
 Malzberg, Benjamin, 3: 1051-66
 Mandelbaum, David G., 2: 436
 Mandy, Arthur J., 1: 11
 Mann, Thomas, 2: 640
 Mao Tse-tung, 1: 250, 251
 Marcel, Gabriel, 2: 585
 Marrett, Robert R., 6: 1897
 Marmor, Judd, 1: 213-16
 Marshall, A., 6: 1908
 Martin, A. R., 5: 1514
 Martin, G. E., 1: 27
 Martin, Peter A., 5: 1501-10
 Masland, Richard L., 4: 1324-32
 Maslow, Abraham H., 2: 595; 5: 1653; 6:
 2039

- Masserman, Jules H., 4: 1333-45
 Maudsley, Henry, 5: 1638
 Maugham, Somerset, 3: 877
 Mausner, B., 6: 2029
 May, Rollo, 2: 588, 593, 594; 5: 1639
 Mayer, E. E., 3: 751
 Mayer, Robert J., 5: 1510
 Mead, G. H., 4: 1472
 Mead, Margaret, 1: 1-8; 2: 415-26; 4: 1251; 5: 1574; 6: 1898, 1901, 1905, 1913
 Meares, Ainslee, 3: 816
 Meduna, L. J., 5: 1676
 Meerloo, J. A. M., 4: 1428
 Mendel, Gregor, 6: 1970
 Mendeleev, Dmitri, 3: 1033
 Menninger, Karl A., 1: 131; 2: 481; 3: 1094; 4: 1244-55, 1464; 5: 1575
 Menninger, William C., 1: 141; 2: 481; 3: 1081, 1101; 4: 1224, 1339; 5: 1575
 Merritt, H. Houston, 2: 570
 Mesmer, Franz, 3: 802, 803; 5: 1723, 1729
 Messalina, 4: 1418
 Messinger, Emanuel, 4: 1407-20
 Meyer, Adolf, 2: 477, 533; 3: 745, 1092; 4: 1104; 5: 1574, 1575, 1639, 1612, 1670, 1734, 1786, 1787
 Meyer, Georg, 2: 685
 Meyerson, Lee, 5: 1506, 1507
 Michon, Jean Hippolyte, 3: 684, 685, 693
 Mill, John S., 3: 1082; 5: 1620
 Miller, Daniel R., 6: 1919
 Miller, Neal, 4: 1170; 5: 1621
 Miller, Robert Earle, 1: 329
 Minkowski, Eugene, 2: 586
 Mirsky, I. Arthur, 5: 1714
 Mitchell, Howard L., 3: 970
 Mitchell, Silas Weir, 3: 711; 4: 1104
 Molière, 6: 1938
 Money, John, 5: 1678-1709
 Monroe, Ruth, 3: 968
 Montagu, Ashley, 3: 950-57; 5: 1668
 Moore, G. E., 1: 331
 Moreno, J. L., 2: 609, 710; 3: 713; 4: 1344
 Morgan, A. H., 6: 1897
 Morgenthau, Hans L., 2: 448
 Morris, Harold H., Jr., 1567-85
 Moses, Grandma, 1: 158
 Mosher, J. Montgomery, 4: 1105
 Mowrer, O. H., 2: 547; 4: 1470
 Mozart, Wolfgang Amadeus, 2: 673
 Mudd, Emily H., 2: 483-97; 3: 965-89
 Müller, Johannes, 5: 1620
 Munroe, Ruth L., 5: 1643, 1652
 Munter, Preston K., 1: 109-25; 4: 1204-12; 6: 2063-78
 Murphy, Gardner, 2: 437-8; 4: 1427, 1430, 1435, 1473
 Murphy, Henry B., 4: 1235-43
 Murray, Gilbert, 4: 1426
 Murray, Henry A., 2: 418; 4: 1260, 1428, 1470, 1473, 1478, 1484; 5: 1609, 1618, 1621
 Mussolini, Benito, 4: 1418
 Myers, Frederic W. H., 4: 1422, 1426, 1428
 Myers, Frederick, 2: 437
 Myrdal, Alva, 6: 2013
 Myrdal, Gunnar, 5: 1549
 Nadel, Siegfried, 6: 1901
 Nagy, Maria H., 2: 439, 441
 Nash, C. B., 4: 1428
 Nast, Thomas, 3: 798
 Nation, Carry, 5: 1525
 Neal, M., 4: 1366
 Nebuchadnezzar, 4: 1336
 Nechavez, Sergei G., 5: 1525
 Negovskii, V. A., 2: 427
 Nelson, Janet F., 3: 989
 Nero, 4: 1418
 Newcomb, Simon, 4: 1426
 Newman, Horatio N., 4: 1274
 Newman, S., 2: 554
 Newton, Isaac, 5: 1581
 Nicol, Betty Humphrey, 4: 1430
 Niebuhr, Reinhold, 5: 1580
 Nietzsche, Friedrich, 2: 585; 4: 1244, 1418; 5: 1674; 6: 2001
 Nisbet, J. D., 4: 1445
 Nissl, Franz, 3: 741
 Nkrumah, Kwame, 6: 2031
 Norbeck, Edward, 2: 434
 Novak, F. R., 3: 1029
 Noves, Arthur P., 1: 167; 4: 1413
 Nunnally, Jum C., 5: 1627
 Oates, Lawrence, 2: 434
 Oberndorf, C. P., 5: 1639
 Ogburn, William F., 2: 418
 Ohlin, Lloyd, 3: 896
 Opler, Marvin, 4: 1335; 6: 1900, 1902, 1905
 Opler, Morris, 6: 1902, 1905
 Orenstein, Leo L., 1: 144-52
 Orme, Martin, 3: 805
 Orr, Douglass W., 1: 126-43; 2: 643-60; 3: 831-49; 6: 1867-85, 1962-9
 Ortega y Gasset, José, 2: 585
 Orton, Samuel Torrey, 2: 700
 Osis, Karlis, 2: 437; 4: 1428
 Osler, William, 2: 439
 Osmond, H., 4: 1335
 Overholser, Winfred, 5: 1643, 1653
 Ovesey, Lionel, 5: 1550
 Paine, Thomas, 2: 475
 Parker, Seymour, 6: 1903
 Partridge, G. E., 5: 1639

- Paterson, Donald G., 5: 1609
 Paton, Stewart, 3: 1080
 Paul, Benjamin, 6: 1902
 Pavlov, Ivan P., 1: 315; 3: 745, 763; 4: 1105, 1341, 1397, 1398; 5: 1570, 1571, 1575, 1621, 1729, 1786
 Peel, Robert, 3: 909
 Peller, Lili, 5: 1517
 Peltz, William L., 3: 973
 Penfield, Wilder, 2: 570, 680; 3: 858, 998
 Pershing, John J., 4: 1106
 Persky, Harold, 6: 1977
 Peterson, James A., 3: 968, 969
 Petrie, Asenath, 4: 1386-1406
 Pettigrew, Thomas F., 5: 1553
 Pfanne, Heinrich, 2: 694
 Pfister, Oskar, 2: 641
 Phelps, Winthrop, 4: 1197
 Phipps, Henry, 3: 1093
 Piaget, J., 1: 330
 Picasso, Pablo, 3: 877
 Piccard brothers, 4: 1274
 Pinel, Philippe, 3: 740; 4: 1345; 5: 1573, 1638, 1671, 1729
 Pintner, Rudolf, 5: 1609
 Pittenger, Robert E., 1: 333
 Pitt-Rivers, Augustus H., 6: 1897
 Pius XI, 6: 1972
 Plant, James L., 2: 417
 Plato, 2: 401; 3: 737, 759, 794; 4: 1222, 1244, 1336, 1337, 1425; 5: 1511, 1637
 Plotinus, 4: 1233
 Poe, Edgar Allan, 3: 817; 5: 1674
 Poincaré, Raymond, 3: 877
 Pokorny, R., 2: 699
 Polatin, Phillip, 4: 1154-64
 Pomeroy, W. B., 1: 27
 Popenoe, Paul, 6: 1971
 Pophal, Rudolf, 2: 686
 Porteus, Stanley D., 5: 1609
 Pound, Roscoe, 5: 1646
 Pratt, J. G., 4: 1422, 1431
 Preston, Malcolm G., 3: 973
 Preyer, Wilhelm, 2: 685
 Price, H. H., 4: 1428
 Prichard, J. C., 5: 1637
 Prince, Morton, 4: 1426, 1428; 6: 2001
 Prince, Walter Franklin, 4: 1426
 Prugh, Dane G., 4: 1439
 Pruyser, Paul W., 4: 1244-55
 Pulver, Max, 2: 686, 695
 Pumpian-Mindlin, Eugene, 5: 1586-1604
 Putnam, T. J., 2: 570
 Puysegur, Marquis de, 3: 803
 Pythagoras, 2: 681
 Rackman, Emanuel, 6: 1973
 Radcliffe-Brown, A. R., 6: 1897, 1898
 Radin, Paul, 6: 1897
 Rado, S., 4: 1335; 5: 1574, 1576, 1593
 Rank, Otto, 2: 640, 641; 5: 1574, 1592
 Rapoport, Robert N., 6: 1896-1906
 Ray, Isaac, 5: 1638
 Rayleigh, Lord, 4: 1426, 1428
 Read, Grantley Dick, 4: 1398
 Redl, Fritz, 5: 1769-81, 1812; 6: 1912, 1996
 Redlich, Frederick C., 2: 566; 3: 1061; 5: 1572, 1675; 6: 1900, 1915, 1923
 Reed, James C., 3: 930-49
 Reed, Louis S., 4: 1146-53
 Rees, John R., 3: 1099; 5: 1524; 6: 2049-62
 Reich, Wilhelm, 2: 641; 5: 1593
 Reid, John R., 3: 855
 Reider, Norman, 2: 481
 Reik, Theodor, 1: 333; 2: 641; 3: 797; 5: 1593
 Reil, Johann, 3: 740
 Reiser, Morton F., 5: 1710-21
 Rennie, Thomas A. C., 2: 568; 4: 1340; 6: 1900
 Rhine, J. B., 2: 438; 4: 1421, 1422, 1426, 1427, 1428, 1431
 Richet, Charles, 4: 1426, 1428
 Richmond, Julius B., 1: 287-302
 Richter, Curt, 2: 447
 Ridenour, Nina, 3: 1091-1102
 Riggs, Austen Fox, 4: 1081
 Rivers, William H. R., 6: 1897
 Roberts, Lamar, 2: 680
 Rockmore, Myron J., 6: 1941-51
 Rogawski, Alexander S., 6: 2000-2006
 Rogers, Carl, 2: 595, 711; 3: 743; 4: 1483; 5: 1621, 1734
 Róheim, Géza, 2: 417; 6: 1900
 Roman, Klara G., 2: 679-702
 Rome, Howard P., 3: 766-74
 Roosevelt, Franklin Delano, 5: 1528
 Rorschach, Hermann, 5: 1609
 Rosen, Bernard C., 4: 1444, 1445
 Rosen, Harold, 1: 9-28; 3: 800-817
 Rosenbaum, Milton, 5: 1712 n.
 Rosenfeld, Eva, 4: 1279
 Rosenthal, Arthur J., 2: 481
 Rosenthal, David, 1: 724-35
 Rosenzweig, Saul, 6: 1977
 Rostov, Edna, 3: 1081
 Royce, Josiah, 4: 1426
 Rubenstein, Boris B., 3: 1027, 1029
 Ruesch, Jurgen, 1: 333; 6: 1900
 Ruggles, Arthur, 3: 1081
 Rush, Benjamin, 4: 1344; 5: 1574, 1638, 1671; 6: 2008
 Russell, Bertrand, 1: 331
 Kyle, G., 1: 331

- Sachs, Hans, 2: 641
 Sakel, M. J., 5: 1676, 1796
 Salk, Jonas, 5: 1767
 Salmon, Thomas W., 3: 1093, 1094, 1102;
 4: 1106, 1214; 5: 1574
 Salter, Andrew, 3: 745
 Sapir, Edward, 1: 327; 2: 417
 Sarason, Seymour, 4: 1184, 1185, 1195
 Sarbin, T. R., 4: 1472
 Sargent, Porter, 2: 675
 Sartre, Jean-Paul, 2: 584, 585
 Satten, Joseph, 2: 367-80, 402-14
 Saudek, Robert, 2: 687
 Saul, 4: 1336; 5: 1755
 Saul, Leon, 2: 489
 Schacfer, Theodore, Jr., 3: 859-71
 Schilder, Paul, 2: 429, 440, 518, 711; 3: 742,
 743
 Schlaifer, Charles, 2: 481
 Schmeidler, Gertrude R., 4: 1428, 1431
 Schneider, Rudi, 4: 1433
 Schoggen, Phil, 5: 1501-10
 Schopenhauer, Arthur, 6: 2001
 Schottland, Charles L., 2: 481
 Schreiber, Julius, 2: 473-82
 Schweitzer, Albert, 5: 1580
 Scott, John Paul, 3: 869, 870
 Sears, R. R., 4: 1470
 Serchehayc, M. A., 4: 1335
 Seguin, Edouard, 4: 1188
 Seligman, C. G., 2: 417
 Selye, Hans, 5: 1571; 6: 1979
 Shackleton, Basil, 4: 1427
 Shakow, David, 2: 481; 5: 1618-33
 Shankaracharya, 4: 1233
 Shannon, C. F., 1: 329
 Shaw, G. B., 2: 475, 545, 681
 Shaw, Henry Wheeler (Josh Billings) 3: 786
 Sheldon, William H., 2: 355-66; 4: 1468;
 5: 1575, 1666
 Sherif, Muzafer, 4: 1460
 Shurley, Jay T., 5: 1837
 Sidgwick, Henry, 4: 1425, 1426, 1428
 Sidis, William, 4: 1105
 Simburg, Pearl E., 2: 481
 Simmons, Ozzie, 6: 1902
 Simon, Alexander, 5: 1782-98
 Simpson, George Gaylord, 2: 584
 Skinner, B. F., 2: 547; 5: 1621
 Slater, E. T., 4: 1269
 Slavson, S. R., 2: 711; 3: 743
 Smith, Ethel Sabin, 3: 969
 Smith, Geddes, 3: 1101
 Smith, L. H., 1: 327
 Smith, M. Brewster, 5: 1552
 Snyderman, B., 6: 2029
 Snygg, Donald, 4: 1472
 Soal, S. G., 4: 1427
 Socarides, Charles, 3: 755
 Socrates, 2: 429, 544
 Soddy, Kenneth, 3: 827-33
 Sontheimer, Morton, 1: 20
 Soskin, William, 5: 1766
 Southard, E. E., 5: 1639
 Spearman, Charles, 5: 1621
 Spencer, Herbert, 4: 1261
 Spiegel, John P., 1: 131; 2: 435; 4: 1335;
 6: 1977, 1981
 Spinoza, Baruch, 4: 1233
 Spitz, René, 1: 75, 76; 2: 464, 609; 4: 1438;
 5: 1682
 Spock, Benjamin, 5: 1630
 Stalin, Joseph, 5: 1523, 1524
 Stanley brothers, 4: 1274
 Star, Shirley A., 4: 1306-11
 Steele, Richard, 4: 1469
 Steffens, Lincoln, 2: 475
 Steiner, M. Elisabeth, 1: 217-26
 Stekel, W., 2: 438, 640
 Stephenson, W., 4: 1472
 Sterba, R., 4: 1339
 Stern, Edith M., 1: 153-78; 4: 1180-1203,
 1291
 Stevens, Harold, 1: 235-49
 Stevens, S. S., 2: 357
 Stevenson, Adlai E., 1: 143
 Stevenson, George S., 2: 481; 3: 1095, 1101;
 4: 1106
 Stevenson, Ian, 4: 1428
 Stevenson, Robert L., 3: 821
 Steward, Julian, 6: 1898
 Stewart, Donald Ogden, 3: 796
 Stierlin, Helm, 5: 1664-77
 Stokes, A. B., 6: 1996
 Stone, Abraham, 3: 968, 989
 Stone, Hannah M., 3: 968
 Stone, I. F. 2: 481
 Stouffer, Samuel A., 5: 1554
 Stratton, F. J. M., 2: 438
 Straus, Erwin, 2: 586
 Strawson, P. F., 1: 331
 Strecker, Edward A., 5: 1574, 1645
 Strindberg, August, 5: 1674
 Strong, Edward K., Jr., 4: 1473; 5: 1609
 Stunkard, Albert, 4: 1372-85
 Suci, G., 4: 1444
 Suetonius, 2: 684
 Sullivan, Harry Stack, 2: 417, 641; 3: 742,
 854; 4: 1340, 1470, 1473; 5: 1574, 1575,
 1593, 1601, 1670, 1672, 1734; 6: 1927
 Swanson, Guy E., 6: 1919
 Swedenborg, Emanuel, 4: 1425
 Symonds, P. M., 4: 1472
 Szasz, Thomas S., 4: 1403

- Tawney, R. H., 4: 1251
 Tchaikovsky, P. Ilich, 3: 759
 Temkin, Owsei, 2: 570
 Terman, Lewis M., 2: 387, 662, 663, 665, 676; 3: 884; 4: 1473; 5: 1608
 Theophrastus, 4: 1469
 Thigpen, Corbett H., 6: 2001
 Thomas (apostle), 4: 1274
 Thomas, Dylan, 2: 429
 Thompson, George N., 5: 1641
 Thompson, Robert, 3: 998-1010
 Thomson, G. H., 4: 1472
 Thoreau, Henry David, 2: 475; 4: 1340, 1345, 1580
 Thorndike, Edward L., 4: 1461; 5: 1621
 Thouless, R. H., 4: 1428
 Thudichum, J. L. W., 1: 227
 Thurstone, L. L., 4: 1472; 5: 1609
 Tiller, Per Olav, 4: 1443
 Tillich, Paul, 2: 438, 585, 590, 592; 4: 1340; 5: 1580
 Tillman, William, 1: 32
 Tinbergen, Niko, 3: 863, 866, 867, 868, 869
 Titchener, E. B., 5: 1621
 Tolman, Edward C., 4: 1258; 5: 1621
 Tolstoi, L., 2: 444, 475; 3: 877; 5: 1580
 Torrance, E. Paul, 2: 667-78
 Trager, George L., 1: 325, 326, 327, 328, 331
 Truman, Harry S., 5: 1528
 Tucker, W. B., 2: 357
 Tuke family, 3: 740; 5: 1573
 Tylor, Edward Burnett, 6: 1897
 Tyrrell, G. N. M., 4: 1427

 Ullman, Montague, 4: 1121, 36
 Ungerleider, Harry E., 1: 132

 Van Kaam, Adrian, 2: 595
 Veblen, Thorstein, 2: 475; 6: 1938
 Verdi, Giuseppe, 3: 877
 Vernon, P. E., 2: 679, 687
 Veroff, J., 2: 1075
 Vinci, Leonardo da, 2: 701
 Vogel, Ezra F., 3: 968
 Von Mendelssohn, Felix, 2: 460-72

 Waelder, Robert, 2: 641; 5: 1511, 1518, 1593
 Wagner von Jauregg, Julius, 5: 1676
 Wahl, Charles W., 2: 441
 Wallace, Anthony F. C., 3: 990-97; 6: 1904
 Wangh, Martin, 5: 1485-93
 Warner, Lucien, 4: 1429
 Warren, Howard, 2: 547
 Washington, George, 3: 802; 5: 1793
 Watson, John B., 4: 1105; 5: 1621, 1787
 Wattenberg, William W., 5: 1799-1828
 Watts, James W., 5: 1722, 1787
 Waxenberg, Sheldon E., 5: 1494-1500
 Weber, Max, 4: 1251

 Wechsler, David, 2: 440; 5: 1608
 Wedge, Bryant M., 3: 1089
 Weihofen, Henry, 3: 775-85; 1858-66
 Weinberg, Abraham, 4: 1354-71
 Weinberg, Patricia W., 2: 513-4
 Weinberg, S. K., 3: 837; 5: 1641
 Weinstein, Edwin A., 5: 1668
 Weissman, Avery, 2: 447
 Weitzenhoffer, A., 3: 816
 Welch, William H., 3: 1091
 Welles, Olson, 3: 996
 Wender, Louis, 2: 711; 3: 743
 Werkman, Sidney L., 1: 303-12
 Wernicke, C., 5: 1666
 Wesley, John, 3: 996; 4: 1425
 West, Charles, 1: 313
 West, Louis Jolyon, 1: 250-57; 5: 1837-41; 6: 1886-95
 Wetherill, G. Gage, 5: 1845
 Weyer, Johann, 3: 740
 White, Leslie, 6: 1898
 White, William A., 4: 1105; 5: 1574, 1671
 White, Robert W., 5: 1552
 Whitehead, Alfred North, 4: 1333
 Whiting, John, 6: 1902
 Whitman, Walt, 2: 475; 3: 759; 5: 1580
 Wickman, E. Koster, 5: 1806
 Wiener, Norbert, 1: 330
 Wieser, Roda, 2: 694, 695
 Wilmer, Harry A., 6: 1996
 Winch, Robert F., 1: 137
 Wineman, David, 5: 1812; 6: 1912
 Wisdom, John O., 1: 331
 Witkin, H. A., 4: 1460
 Witmer, Lightner, 4: 1106
 Wittgenstein, Ludwig, 1: 331
 Wittkower, E. D., 4: 1341, 1342
 Wittman, Phyllis, 2: 362
 Wohl, M. G., 5: 1495
 Wolff, Werner, 2: 691
 Wolfson, Rose, 2: 687, 868
 Wollen, R., 4: 1363
 Wood, Grant, 1: 131
 Woodruff, J. L., 4: 1428
 Woodworth, Robert S., 4: 1258; 5: 1621
 Worcester, David, 3: 798
 Wortis, S. Bernard, 4: 1276-85
 Wright, B. A., 5: 1505, 1506, 1508
 Wright, H. W., 5: 1639
 Wundt, W., 5: 1620

 Yannett, Herman, 4: 1182
 Young, Paul Thomas, 4: 1256-66

 Zenoff, Elyce H., 6: 1970-74
 Zillboorg, Gregory, 2: 438; 3: 738, 740, 857; 5: 1758
 Ziskind, Eugene, 5: 1570
 Zubin, Joseph, 2: 687

SUBJECT INDEX

- A.A. *See* Alcoholics Anonymous
A.A.P.S.W. *See* American Association of Psychiatric Social Workers
A.B.E.P.P. *See* American Board of Examiners in Professional Psychology
Abnormal psychology, 2: 689, 696
Abortion, 1: 9-28, 351; 2: 395; 5: 1531, 1536; 6: 1961
"Abortion in America Today" (Sontheimer), 1: 20
Abortion in the United States (Caldevone, ed.), 1: 14, 27
Abreaction and abreactive techniques, 1: 135; 3: 856; 6: 2053
Absenteeism, 6: 2029, 2037
Abstinence syndrome, 4: 1280-81
Academy of Child Psychiatry, 4: 1183
Academy of Religion and Mental Health, 5: 1756, 1759
Accident proneness and accidents, 1: 29-36, 188, 236; 2: 717; 3: 780; 4: 1201, 1294, 1161; 5: 1558; 6: 1988, 2029, 2037
Acculturation, 4: 1240-43, 1246, 1478; 5: 1590
Achievement and achievement tests, 1: 217-218; 2: 668; 3: 885, 886, 944; 5: 1518, 1519, 1802
Acne, 1: 52, 53
Acrophobia, 5: 1185, 1187, 1490
Act for the Prevention of Idiocy, 6: 1971
A.C.T.H., 6: 1979
Acting-out, 1: 33, 80; 3: 905; 5: 1779; 6: 1902, 1922
Action for Mental Health (Int. Commission on Mental Illness and Health), 1: 274; 5: 1627
"Action research," 6: 1906
Activist viewpoint, 1: 111
Adaptability, 2: 537; 4: 1228
Addiction, 2: 553; 3: 1016, 1050; 4: 1279, 1343, 1402; 5: 1661
See also Alcoholics; Drug addiction; Narcotic addiction
Addiction Research Center (NIMH), 4: 1296
Addison's disease, 3: 662, 769, 770
Adjustment techniques. *See* Mental mechanisms
Adolescence and adolescents, 1: 37-69, 136, 149-50, 292, 313; 2: 388-90, 408, 421, 425, 431, 463, 489, 506, 512, 519, 617; 3: 793, 823, 896, 899, 1014, 1074, 1083, Adolescence and adolescents (*Cont.*) 1089; 4: 1342, 1380-81; 5: 1517, 1590, 1611, 1706-8, 1844; 6: 1902, 1991, 2021
emotional disturbances, 5: 1820-21
mores, 1707-8
Adolph Meyer Memorial Award, 2: 477
Adoption, 1: 68, 70-108, 339; 3: 833; 6: 1945, 1948, 1967
"Adoption of Children" (Amer. Acad. of Pediatrics), 1: 84, 98
Adrenalin and adrenals, 1: 37, 229, 233; 2: 549; 3: 767, 768, 770; 4: 1396, 1397
Adulthood, 1: 109-143
male, 126-143
See also Young adulthood
Advertising, 5: 1629; 6: 1938
Affect and affect hunger, 3: 951; 5: 1619, 1630; 6: 2069
Affectionless character, 5: 1560
Affluent society, 1: 45, 119-20
A.F.Q.T. *See* Armed Forces Qualification Test
Africa, 3: 447, 565, 601; 6: 1901, 1910, 1964, 2007, 2051, 2052, 2056
Aftercare and aftercare clinics, 4: 1105, 1111, 1144, 1177-8; 5: 1658
After Divorce (Goode), 2: 485, 495; 3: 974
Afterlife, 5: 1754-5
See also Immortality
A.G.C.T. *See* Army General Classification Test
Aged and aging, 1: 111, 127-30, 136, 139, 143, 149, 153-78; 2: 398-9, 435, 457, 488, 525, 538-9, 562, 627, 641, 726, 729; 3: 744, 777, 837, 839, 840, 852, 855, 876-7, 920, 934, 962, 969, 1006, 1009, 1017, 1018, 1056, 1076, 1086; 4: 1119, 1123, 1132, 1135, 1144, 1168-9, 1205, 1206, 1208, 1209, 1210, 1205, 1296, 1326, 1342, 1366, 1371, 1374, 1460-1461, 5: 1504, 1514, 1526, 1562, 1630, 1662-3, 1709; 6: 1941, 1953, 1982, 2021, 2057
See also Geriatrics; Golden Age; Retirement; Senile psychoses; Senior citizens
Agencies, 3: 904, 984; 4: 1178, 1209; 5: 1581-1582; 6: 1945, 2024, 2079-85
"Age of Anxiety," 1: 215-6, 296; 6: 1981, 2068
Age of Psychology, The (Havemann), 5: 1630

- Aggression* (Scott), 3: 869
- Aggression and aggressiveness*, 1: 66, 126, 131, 144-52, 296; 2: 404, 408, 456, 624, 626, 636, 652; 3: 753, 789, 792, 794, 843, 869, 870, 917, 952, 991, 1071; 4: 1156, 1162, 1165, 1339, 1359, 1404, 1409, 1442, 1446; 5: 1527, 1530, 1541, 1567, 1591, 1749; 6: 1967, 1988, 2005, 2064, 2073, 2074
- Aggressive Child, The* (Redl and Wineman), 5: 1812
- Agitators*, 5: 1524-5
- Al-Anon Family and Alateen groups*, 1: 199-200; 6: 2080
- Albany (N.Y.) Hospital*, 4: 1105
- Albert Deutsch Award*, 3: 481
- Albert Deutsch, Crusader*, 2: 473-82
- Albert Deutsch Memorial Foundation and Memorial Lecture*, 3: 481, 482
- Alcoholics and alcoholism*, 1: 32, 35, 123, 135, 146, 179-204, 237, 239, 324, 344; 2: 422, 462, 502, 508, 542, 563, 565, 566, 658, 726, 727, 731, 732; 3: 772, 812, 835, 846, 981, 991; 4: 1109, 1111, 1119, 1131-2, 1161, 1175, 1210, 1213, 1222, 1276, 1294, 1295, 1334, 1337, 1338, 1399, 1400, 1405, 1442, 1443; 5: 1557, 1558, 1564, 1565, 1576, 1578, 1631, 1662, 1730; 6: 1870, 1882, 1902, 1908, 1921, 1955, 2012, 2031, 2036, 2037, 2057, 2071, 2080
- psychoses*, 2: 466; 3: 1056, 1057, 1060, 1062, 1064
- Alcoholics Anonymous*, 1: 197-8, 200, 201; 2: 422, 553, 709, 713; 3: 743; 4: 1132, 1344; 6: 2079
- Alienation*, 5: 1760; 6: 1920, 1921
- Alien syndrome*, 2: 564
- A.M.A. See American Medical Association*
- Ambivalence*, 1: 291; 2: 536
- Amebiasis*, 1: 243
- Amenorrhea*, 3: 771, 1011, 1014, 1015, 1026, 1030
- American Academy for Cerebral Palsy*, 4: 1330-31
- American Academy of Child Psychiatry*, 1: 316
- American Academy of Neurology*, 4: 1330
- American Academy of Pediatrics*, 1: 84
- American Anthropological Association*, 6: 1899
- American Association of Group Workers*, 6: 1947
- American Association of Marriage Counselors*, 2: 497; 3: 985, 988
- American Association of Medical Social Workers*, 6: 1947
- American Association on Mental Deficiency*, 4: 1181
- American Association of Neuropathologists*, 4: 1330
- American Association of Psychiatric Clinics for Children*, 3: 1094
- American Association of Psychiatric Social Workers*, 3: 1094; 6: 1947, 1950, 1951
- American Bar Association*, 4: 1285
- American Bar Foundation*, 5: 1859, 1862
- American Board of Examiners in Professional Psychology*, 5: 1623, 1624
- American Board of Examiners in Psychiatry*, 1: 264, 315
- American Board of Neurological Surgery*, 4: 1330
- American Board of Pathology*, 4: 1330
- American Board on Professional Standards in Vocational Counseling*, 1: 223
- American Board for Psychological Services*, 1: 223
- American Board of Psychology and Neurology*, 3: 1094; 4: 1123; 5: 1577, 1583, 1623
- American Classification*, 3: 1041, 1047-50
- American College of Surgeons*, 4: 1331
- American Correctional Association*, 2: 379
- American Dilemma, An* (G. Myrdal), 5: 1549
- American dream*, 6: 1936
- American Electroencephalographers Society*, 4: 1330
- American Epilepsy Federation*, 2: 579
- American Epilepsy Society*, 2: 577, 580
- American Families* (Glick), 2: 492
- American Foundation for Mental Hygiene*, 2: 476
- American Fund for Psychiatry*, 5: 1767
- American Gothic* (Wood), 1: 131
- American Group Psychotherapy Association*, 2: 712
- American Hospital Association*, 4: 1123
- American Indians*, 3: 793; 6: 1901, 1902, 1903, 1904, 1905
- American Institute of Public Opinion*, 2: 438
- American Law Institute*, 1: 28
- American Medical Association*, 1: 15, 274; 3: 800, 805, 806, 810, 811, 812, 814, 816; 4: 1047n., 1284, 1285, 1361; 5: 1571
- Council on Medical Education*, 4: 1123
- Council on Mental Health*, 1: 316
- American Medico-Psychological Association*, 3: 1093
- American Neurological Association*, 4: 1330; 6: 1973
- American Newspaper Guild*, 2: 476
- American Occupational Therapy Association*, 1: 274

- American Orthopsychiatric Association, 1: 315; 3: 1094
- American Personnel and Guidance Association, 1: 223
- American Psychiatric Association, 1: 167, 274, 315-6; 2: 477; 3: 815, 1034, 1040, 1093, 1094, 1097; 4: 1123, 1124, 1125, 1133, 1134, 1285, 1287, 1291, 1307, 1350; 5: 1574; 6: 2037, 2079
classification, 3: 1041, 1042-7
Comm. on Nomenclature, 5: 1164-5
Comm. on Religion and Psychiatry, 5: 1756
- American Psychoanalytic Association, 1: 316; 5: 1594, 1599, 1731
- American Psychological Association: 1: 275; 3: 891; 5: 1582, 1594, 1606, 1623, 1624, 1626, 1632, 1731; 6: 2079
Comm. on Religion and Psychiatry, 5: 1756
Div. of Clinical Psychiatry, 5: 1731
- American Public Health Association, 1: 316
- American Public Welfare Association, 6: 2079
- American Red Cross, 2: 379; 4: 1219; 6: 2079
- American Society for Group Psychotherapy and Psychodrama, 2: 712
- American Society for Psychical Research, 2: 437; 4: 1424, 1426, 1428
- American Society for the Study of Sterility, 6: 1962
- American Soldier, The* (Stouffer *et al.*), 5: 1554
- American Speech and Hearing Association, 6: 1960, 2080
- American Standard Classification, 3: 1033
- American Surgical Association, 4: 1331
- Americans View Their Mental Health* (Gurin, Veroff, and Feld), 1: 126, 132; 2: 563; 3: 1074
- Amino acid metabolism, 1: 231; 2: 575
- Amnesia, 3: 821, 830, 999; 4: 1008, 1010, 1157, 1158, 1164; 6: 1892
- Amphetamines, 1: 228; 4: 1276, 1381, 1408; 5: 1656
- Anaclitic depression, 2: 464
- Analgesics and anesthesia, 2: 518; 3: 1031; 4: 1276, 1315, 1366, 1396
- Analogies tests, 3: 885
- Anal phase/stage, 1: 281-2, 291, 294; 4: 1409; 5: 1589
- "Analysis of a Phobia in a Five-Year-Old Boy" (S. Freud), 5: 1488
- Analytic psychology, 4: 1340
See also Psychoanalysis
- Ancylostomiasis, 6: 1908
- And Keep Your Powder Dry!* (Mead), 1: 126
- Andric endowment, 2: 360, 361
- Androgens and androsterone, 3: 765, 768
- Anger, 1: 79, 296, 305; 2: 547, 548, 549, 550; 4: 1390; 6: 2016, 2047
See also Rage
- Animal experiments and psychology, 1: 205-211, 288, 328, 334; 3: 862, 863, 866, 867, 869, 871, 1003; 4: 1316, 1317, 1341, 1372, 1434; 5: 1619, 1682, 1684-1685, 1763, 1837
- Anorexia nervosa*, 4: 1378
- Anosmia, 1: 239
- Anovulatory bleeding, 4: 1013, 1014, 1021, 1024
- Anoxia, 4: 1183
- Antabuse, 1: 195-6; 4: 1162; 5: 1662
- Anthropology, 1: 287, 326, 331; 2: 417, 420, 447, 533, 546, 638; 3: 863, 891; 4: 1251, 1252, 1257, 1434, 1437, 1471; 5: 1569, 1574, 1760, 1764; 6: 1923, 2005, 2051
See also Cultural anthropology; Social anthropology
- Antibiotics, 4: 1192, 1325
- Anticonvulsants, 2: 570, 578; 4: 1325
- Antidepressants, 1: 229, 354; 2: 470, 471, 472; 3: 746; 4: 1173; 5: 1499, 1654, 1788
- Antidiuretic hormone, 3: 768
- Antihistamines, 1: 244
- Antisocial activity. *See* Aggression
- Anxiety and anxiety states, 1: 110, 123, 145, 146, 181, 212-6, 296-7, 303-5, 346; 2: 505, 509, 517, 512, 549, 555, 591, 592, 624, 629, 631, 636, 653; 3: 757, 791, 796, 799, 810, 818, 844, 1017, 1021, 1044, 1045, 1047, 1070, 1081; 4: 1154, 1165, 1210, 1215, 1216, 1222, 1238, 1241, 1249, 1264, 1333, 1334, 1340, 1341, 1342, 1366, 1403, 1463, 1480, 1481; 5: 1487, 1489, 1594, 1655, 1656, 1673, 1716, 1805, 1838; 6: 1893, 1910, 1919, 1939, 1966, 1975, 1977, 1978, 1989, 2009, 2050, 2051, 2065, 2066, 2069, 2076, 2078
"Age of," 1: 215-6, 296; 6: 1981, 2068
- A.P.A. *See* American Psychiatric Association
- Apathy and apathy deaths, 1: 256, 301; 2: 435, 460, 630, 704; 6: 1979, 2029
- Aphasia, 1: 239, 240; 2: 695, 697; 6: 1952, 1954, 1955, 1959
- Aphrodisiacs, 2: 657-8; 3: 846
- Aplasia, 3: 360
- Appetate, 4: 1360
- Appetite, 2: 460, 464, 625-7; 3: 866; 4: 1163, 1358-60, 1381-2
- Aptitude testing, 1: 217-26, 265; 2: 668, 692, 693; 3: 881, 885, 932, 933; 5: 1605, 1606, 1611, 1629

- Aptitudes and Aptitude Testing* (Bingham), 1: 221
- Arabic medicine, 3: 738
- Archaic consciousness, 4: 1246, 1248
- Architectural Record*, 2: 391
- Architecture, 2: 368; 4: 1140; 5: 1520
- Archives of Criminal Psychodynamics* (Karpman), 3: 761
- Arctic and arctic hysteria, 6: 1901, 1903
- Armed Forces Qualification Test, 4: 1225
- Army Alpha and Beta tests, 3: 885
- Army General Classification Test, 5: 1630
- Art and art therapy, 2: 399-400; 5: 1515, 1575
- Arteriogram, 4: 1328, 1329
- Arteriosclerosis, 2: 461, 472; 3: 1012; 4: 1120, 1408, 1415, 1461, 1464
See also Cerebral arteriosclerosis
- Arthritis, 3: 1017, 1020; 4: 1375; 5: 1494, 1499
- Artificial insemination, 1: 340
- Art of Satire, The* (Worcester), 3: 798
- As Boys Grow* (film), 5: 1845
- Asia and Asian-Americans, 2: 416; 6: 2051, 2053, 2056
- Aspirin, 4: 1276, 1393, 1399
- A.S.P.R. *See* American Society for Psychical Research
- Assembly line process, 6: 2011
- Assessment method (personality), 4: 1470
- Associated Hospital Service (N.Y.C.), 4: 1148
- Association of Educators of Gifted Children, 2: 676
- Association for Improving the Condition of the Poor, 6: 1912
- Association of Medical Superintendents, 4: 1104
- Association of Psychiatric Social Workers, 5: 1731
- Association for Research in Nervous and Mental Diseases, 4: 1331
- Association for Retarded Children, 3: 775
- Association for the Study of Community Organization, 6: 1947
- Asthenic type, 3: 960; 4: 1468
- Asthma and bronchial asthma, 2: 554; 4: 1264; 5: 1712, 1720
- Atascadero State Hospital (Calif.), 5: 1861
- Atavistic unconscious, 4: 1340
- Athletics, 1: 65, 135-6; 2: 362; 3: 805-6, 933; 4: 1468; 5: 1513; 6: 1934, 2066
- Atlas of Men* (Sheldon, Dupertuis, and McDermott), 2: 357
- Atomic energy and Atomic Energy Commission, 4: 1305; 6: 2069
- Atomistic approach (handwriting), 2: 685
- Atonement, 2: 716, 717, 718; 4: 1250; 6: 1988
- Augmentors (pain), 4: 1392, 1393
- Aura. *See* Epilepsy
- Australia, 4: 1434; 5: 1531, 1571
- Austria, 1: 10, 30; 2: 710; 3: 743, 802; 6: 1970, 1983, 1984
- Authoritarianism, 1: 66; 2: 602; 5: 1526, 1553, 1578; 6: 2058
- Authoritarian Personality* (Adorno *et al.*), 5: 1526, 1552
- Authority figures, 5: 1561
- Autism. *See* Infantile autism
- Autobiography* (S. Freud), 2: 632
- Automatic writing, 4: 1158
- Automation, 1: 7; 4: 1201; 6: 1910, 2039-2040, 2068
- Automobile accidents, 4: 1461; 5: 1558
- Autonomic nervous system, 1: 213; 3: 1025; 4: 1311; 5: 1763
- Autonomous ego, 4: 1340
- Aversion, 2: 548; 4: 1258
See also Hate
- Avitaminosis, 4: 1357
- Avoidance, 5: 1546
- Axon activity, 4: 1317-8
- "Baby blues." *See* Postpartum depression
- Baltimore Health District Study, 3: 1052
- Bantu Cancer Registry, 2: 117
- Barbiturates, 1: 228, 244; 2: 508, 533; 3: 745; 4: 1276, 1281, 1343; 5: 1558
- Barrenness anxiety, 5: 1688
- Basic personality structure, 6: 1900, 1903
See also Personality development
- "Battle of the Experts." *See* Expert testimony
- Bayley chart. *See* Nancy Bayley chart
- Because you like people . . . choose a career in Mental Health* (N.A.M.H.), 4: 1290
- Becoming, 4: 1470, 1484; 5: 1571; 6: 2029
- Bed-wetting. *See* Enuresis
- Behavior, 1: 123; 2: 402, 533, 535, 727, 735; 3: 765-74, 776, 787, 859, 867, 1072, 1073, 1076; 4: 1256, 1259, 1313-23, 1337, 1346, 1348-9, 1352; 5: 1618, 1619, 1632
- Behavioral Science* (publication), 6: 1899
- Behavioral sciences, 3: 860, 927, 929
- Behaviorism, 2: 547, 554; 3: 827, 860, 863, 866, 868, 869; 5: 1509, 1621
- Being, 4: 1484
- Being Married* (Duvall and Hill), 3: 968
- Belgium, 1: 30
- Belladonna, 1: 244
- Bellevue Hospital (N.Y.C.), 4: 1105
- Bellevue-Wechsler Test, 2: 540
- Benzedrine, 1: 135; 3: 745; 4: 1082, 1276; 5: 1656

- Berdache, 6: 1904
 Bereavement, 2: 525, 527, 528, 531
 Beriberi, 4: 1365
 Beinreuter Scale, 5: 1609
 Bestiality, 5: 1849
Beyond the Pleasure Principle (S. Freud), 2: 446
 Bicêtre Hospital (Paris), 3: 740
 Biochemistry, 1: 259; 2: 728, 730; 3: 949; 4: 1191, 1375; 5: 1569, 1584, 1656, 1660, 1662, 1687, 1760
 Biological factors and biology, 1: 227-34; 2: 417, 523; 3: 870, 1028; 4: 1354, 1428; 5: 1588, 1618, 1632, 1760, 1762, 1763
 Biometrics Branch (NIMH), 4: 1294, 1297
 Biopsychology, 3: 869
 Birkett Report on the Medical Aspects of Abortion, 1: 27
 Birth control, 1: 13, 28; 5: 1533, 1536, 1538, 1539, 1545; 6: 1964
 See also Planned parenthood
 Birth fantasies, 3: 808, 809
 Birth injuries, 1: 146, 236, 238, 241, 305; 2: 575, 581, 663, 4: 1183, 1192, 1273
 Birth order, 1: 64, 298-9, 305; 2: 156, 600; 4: 1271, 1445-7; 5: 1488
 Bisexuality, 3: 756
 psychological, 5: 1680
 Bladder control. *See* Toilet training
 Blanching, 4: 1389
 Blindness, 4: 1208, 1216, 1234, 1324, 1328, 1329; 5: 1494, 1501, 1502, 1505, 1506
 Blood flukes. *See* Schistosomiasis
 Blood sugar, 2: 549; 3: 767; 4: 1365
 Blue Cross and Blue Shield, 4: 1109, 1116, 1117, 1141, 1117 8, 1150
 Blues of pregnancy, 1: 342
 Body build, 2: 357, 363; 5: 1666; 6: 1887
 See also Somatonia and somatotypes
 Body-mind relationship, 3: 746; 4: 1036-7, 1354
 Body odors, 1: 328
 Boer War, 4: 1213
 Borborygmi, 1: 328
 Borderline states, 3: 890; 5: 1527, 1594
 Boston Latin School (Mass.), 6: 1912
Bourgeois Gentleman, Le (Molière), 6: 1938
 Bourne case (abortion), 1: 12
 Brain, 4: 1314, 1315, 1317; 5: 1763
 See also Nervous system
 Brain atrophy, 1: 237, 238
 Brain damage, 1: 227, 235-41, 307-8; 2: 542, 571, 575; 3: 834, 998, 1009; 4: 1196, 1163; 6: 1952, 1960
 Brain disorders, 1: 168, 242-9, 305-7; 3: 1037, 1040, 1042, 1047
 See also Organic brain disorders
 Brain hemorrhage, 1: 238
 Brain regions, 2: 680-81; 4: 1312, 1317, 1373
 Brain scanner, 4: 1325, 1328
 Brain surgery, 2: 570; 3: 746; 5: 1574
 Brain tumors, 1: 243, 245-7; 2: 463, 572; 4: 1325, 1326, 1328
 Brainwashing, 1: 250-57; 3: 1007; 6: 1888
 Brain waves, 6: 1886-7
 Branch hospitals, 4: 1135
Brave New World (Huxley), 1: 340
 Brazil, 3: 887; 4: 1187
 Breaking point, 4: 1396
 Breast vs. bottle feeding, 1: 293, 295; 6: 1939-40
 Briggs Law, 3: 926
 British Broadcasting Corporation, 3: 806
 British Hypnotism Act (1952), 3: 806
 British Medical Association, 1: 27; 3: 800
British Men of Genius (Ellis), 2: 663
 British Mental Health Act (1959), 3: 777, 781
 British Ministry of Health, 1: 27
 British National Health Service, 4: 1152
 British Royal Commission on Marriage and Divorce, 2: 483
 "Broken heart," 3: 955
 Broken homes, 1: 146; 6: 1867
 See also Divorce; Separation
 "Broken Homes in Teenage Adjustment" (Landis), 2: 489
 Bromide psychosis and bromides, 1: 228; 244; 2: 570; 4: 1171, 1276, 1408; 5: 1557, 1563
 Bronchial asthma. *See* Asthma
 Broun Award Committee. *See* Heywood Broun Award Committee
 Brown University (R.I.), 4: 1428
 Bruxism, 6: 1894
Buck vs. Bell, 6: 1971, 1974
 Budapest Medical School, 2: 697
 "Bulldozer," 3: 747
Bulletin of the Menninger Clinic, 3: 1083; 6: 1995
 Bureaucracy, 5: 1526
 Bureau of Medical Services (NIH), 4: 1304
 Bureau of State Services (NIH), 4: 1304
 Business organization, 6: 2028-9
 Caesarean delivery, 3: 810
 Calcium carbamide. *See* under Antabuse
 Calcium metabolism, 3: 768
 California Department of Corrections, 6: 1998
 California Psychological Inventory, 4: 1477
 California Test of Mental Maturity, 2: 668
 Calvinism, 5: 1578
 Cambridge University, 3: 748; 4: 1425, 1428

- Canada, 1: 30; 2: 570; 3: 874, 887; 4: 1135, 1136, 1152, 1153, 1434; 5: 1570, 1571, 1623; 6: 1983
- Cancer, 1: 161; 2: 442, 447; 3: 1022; 4: 1401, 1403; 5: 1494, 1495, 1498, 1500; 6: 1953
- Cannibalism, 6: 1903
- Capital punishment, 2: 411-12; 3: 922
- Carbohydrates, 4: 1356, 1358, 1359
- Cardiovascular disease, 5: 1494-5
- Career Development Awards (NIMH), 5: 1767
- Career Investigator Awards (NIMH), 5: 1767
- Careers in mental health, 1: 258-75; 4: 1142-3
- Caribbean countries, 2: 603
- Casework. *See* Social casework
- Cassel Hospital (London), 6: 1995
- Castrating female, 2: 645, 650, 651
- Castration and castration anxiety, 1: 215; 3: 762; 4: 1249; 5: 1688, 1854
- Cataplexy, 2: 582
- Cataract (eye), 4: 1324
- Catatonia, 5: 1783, 1785
- Catharsis, 3: 825, 826; 6: 1905
- Catholic Association of Hospital Chaplains, 4: 1453
- Catholic church and Catholics, 1: 11, 86, 89; 2: 436, 486; 3: 811; 4: 1433, 1450, 1451, 1453; 5: 1534, 1535, 1536, 1538, 1748, 1751; 6: 1967, 1972, 1984
- Cattell Infant Intelligence Scale, 3: 890
- Causalgia, 4: 1399
- Censor and censorship, 1: 146; 2: 504, 505; 4: 1155
- Census. *See* U.S. Bureau of Census
- Central Inspection Board (A.P.A.), 4: 1093, 1094
- Central nervous system. *See* Nervous system
- Cerebral arteriosclerosis, 1: 159, 168, 228; 2: 562; 3: 852, 1056, 1057, 1059, 1063, 1064; 4: 1481; 5: 1557, 1829, 1830, 1832
- Cerebral meningitis, 4: 1183
- Cerebral palsy, 1: 248; 4: 1196-7; 5: 1495, 1505, 1507; 6: 1953, 1955, 1960
- Cerebrovascular disease, 4: 1327
- Ceylon, 1: 30
- "Change of life," 3: 1020, 1022
See also Menopause
- Chaperonage, 2: 382, 384, 385; 5: 1707
- Character and Personality* (Saudék), 3: 687
- Character disorders, 1: 283-6; 3: 898, 912, 1082; 4: 1337, 1480, 1482; 5: 1594
- Character structure, 1: 276-86; 2: 361, 535; 4: 1482
- Chastity, 5: 1847
- Chemistry, 5: 1762
- Chicago Juvenile Psychopathic Institute, 4: 1106
- Chicken pox, 1: 243
- Child. *See also* Childhood; Children
- Childbirth, 1: 337-54; 2: 644, 648; 4: 1379, 1394; 6: 1868
See also Natural childbirth; Postpartum depression
- Child development, 1: 287-302; 4: 1341, 1463, 1473; 5: 1578, 1630
- Child guidance clinics, 1: 8, 263, 314, 316; 2: 607, 609; 3: 775, 1078, 1092, 1095, 1096; 4: 1106, 1107; 5: 1571, 1574, 1585, 1825
- Child Guidance Clinics: A Quarter Century of Development* (Stevenson and Smith), 3: 1101
- Childhood and Society* (Erikson), 1: 280; 3: 1083
- Childhood emotional disorders. *See* under Children
- Childhood experiences, 2: 629, 637; 4: 1479; 5: 1760; 6: 1911, 1916, 2064
- Childhood sex play and sexuality, 2: 624, 634, 653-4; 5: 1578, 1695-7; 1700-1703, 1749
- Child labor, 5: 1818
- Childlessness, 1: 91-92; 4: 1438; 6: 1962, 1966
- Child molesting, 2: 406; 3: 837, 916; 5: 1863; 6: 2058
See also Pedophilia
- Child psychiatry, 1: 31, 262-4, 308-20; 3: 750; 4: 1133
- Child psychoanalysis, 1: 316; 5: 1520
- Child rearing, 1: 297-8, 306, 342; 4: 1437-1448; 5: 1578, 1690, 1740, 1764, 1788; 6: 1867, 1868, 1875, 1979, 2054, 2055, 2067
- Children, 3: 749-50, 959, 960, 970, 977, 980, 999, 1077; 4: 1265, 1291, 1405, 1474, 1478; 5: 1588-90
and death, 2: 439-42
and obesity, 4: 1379-80
anxieties, 1: 296-303, 305
behavior disorders, 1: 296; 4: 1295, 1342
depressions, 1: 129, 303, 307
ego-states, 2: 519, 520
emotional disorders and disturbances, 1: 259, 297, 303-12; 2: 609; 3: 944; 4: 1106, 1116, 1132-3, 1264, 1439; 5: 1739-40, 1805-7
fantasies, 2: 634; 5: 1486, 1689; 6: 2020
fears and phobias, 1: 304, 307; 3: 750
feeding disturbances, 1: 30, 287, 293-4, 303, 304, 306; 4: 1368, 1440-41
handicapped, 1: 259, 313; 3: 939; 4: 1130; 5: 1521-2

Children (*Cont.*)

- hospitalization, 4: 1432-3, 1439; 6: 2056
- play, 5: 1516-21, 1689, 1801
- residential treatment: 1: 316; 3: 903, 904, 905, 906, 1100; 4: 1109, 1115-20; 5: 1769-81
- retarded, 3: 939; 4: 1133, 1180, 1181, 1190, 1203, 1365
- schizophrenia, 1: 316, 319; 2: 663; 4: 1116, 1182; 5: 1793, 1794
- sleep disturbances, 2: 307
- suicides, 2: 464
- See also* Juvenile; Wechsler Intelligence Scale for Children
- Children in Need of Parents* (Maas and Engler), 1: 74
- Children's Aid Society of New York, 6: 1942
- Children's Bureau. *See* U.S. Children's Bureau
- Children's Hospital (Los Angeles), 2: 580
- Children's Medical Center (Boston), 4: 1439
- Child Welfare League of America, 1: 86, 98; 6: 2079
- Chile, ?: 881
- China, 1: 250-57; 2: 435, 679, 681, 682, 684; 3: 874, 887; 4: 1277, 1369, 1418; 5: 1523; 6: 1901, 2059
- Chloral hydrate, 4: 1276
- Chlorpromazine, 3: 858; 5: 1655
- Choice of neurosis, 5: 1488, 1492
- Choosing for Happiness* (film), 5: 1845
- Chorea, 5: 1669
- Christian Science, 4: 1401, 1433; 5: 1728, 1731
- Chronic illness, 1: 155, 160; 5: 1494-1500
- See also* Mental patients, chronic
- Circumcision, 3: 846
- City College of New York, 4: 1428, 1431
- Civilian Conservation Corps (W.W.II), 1: 44
- Civilian Public Service (W.W.II), 3: 1098
- Civilization and Its Discontents* (S. Freud), 1: 126, 3: 866
- Civil rights, 2: 371, 378; 3: 783; 4: 1170-71, 1177
- Civil service, 2: 574; 4: 1176; 6: 2046
- Civil War, 1: 254
- Clairvoyance, 4: 1421, 1422-3, 1425, 1433
- Clark University (Mass.), 2: 641
- "Classical neurosis," 1: 131
- Classification. *See* A.P.A. classification; American Classification; American Standard Classification; Mental disorders, classification; Psychiatric classification
- Claustrophobia, 5: 1485, 1487, 1490
- Cleanliness. *See* Orderliness

- Cleft palate, 6: 1953, 1955, 1959, 1960, 1961
- Clergy, 1: 259; 2: 436, 660; 3: 1096, 1097; 4: 1209; 5: 1568, 1630
- See also* Pastoral counseling
- Client-centered orientation, 2: 711; 3: 742
- Climacteric, 3: 1016, 1056; 4: 1342
- See also* Male climacteric; Menopause
- Clinical Neuropharmacology Research Center (NIMH), 4: 1296
- Clinical psychology, 1: 265, 315, 316; 2: 369, 418, 688; 3: 775, 980, 986, 1095, 1096; 4: 1111, 1118, 1245; 5: 1608-10, 1623, 1626, 1627, 1730; 6: 2032
- Clinical Studies in Psychiatry* (Sullivan), 3: 854
- Clinical team. *See* Therapeutic team
- Clinics, 1: 262; 3: 608, 904, 905, 1092, 1095; 4: 1138, 1198, 1215, 1454; 5: 1556, 1583, 1740; 6: 1903, 1923, 1930, 1943, 2054, 2076
- See also* Aftercare clinics; Outpatient clinics
- Clowning, 3: 793, 795
- Cluttering, 3: 689, 702
- C.N.S. *See* Central nervous system
- Cocaine, 4: 1276, 1278, 1279
- Codeine, 4: 1276
- Coenotrope, 3: 862
- Coitus interruptus, 6: 1877
- Colitis. *See* Ulcerative colitis
- Collagen diseases, 3: 772
- Collecting (hobby), 5: 1515; 6: 2066
- Collective unconscious, 2: 640; 3: 742; 5: 1734; 6: 2000
- College mental health, 2: 529-31; 3: 1080-90
- See also* Students and mental health
- Colostomy, 5: 1197
- Columbia University (N.Y.), 2: 580; 3: 1085; 4: 1106
- New York School of Social Work, 6: 1945
- Presbyterian Medical Center, 2: 580
- Coma, 1: 235, 238
- Comedians. *See* Humor
- Commission on Chronic Illness, 5: 1494, 1495
- Commitment, 2: 409; 3: 775, 779-84, 908, 912, 917, 921; 4: 1133
- Committee on Industrial Psychiatry (A.P.A.), 6: 2037
- Committee on Medical Aspects of Sports, 3: 805
- Committee on Psychiatry in Industry (G.A.P.), 6: 2036
- Commonwealth Fund, 3: 1095; 4: 1106; 5: 1765
- Communication, 1: 321-35; 2: 535, 615, 616, 618, 681, 683; 3: 745; 4: 1193, 1194,

- Communication (Cont.)**
1294, 1434, 1438; 6: 1900, 1920, 1922, 1981, 2049, 2050, 2068
- Communication, the Social Matrix of Psychiatry** (Ruesch and Bateson), 1: 333
- Communism**, 1: 250-57; 2: 601; 4: 1448; 6: 2059
- Community chests**, 4: 1288; 6: 2079
- Community education**, 3: 1100; 5: 1556, 1559, 1562, 1564
- Community groups**, 4: 1107; 5: 1514; 6: 1942
- Community hospitals**, 4: 1113; 6: 1994
- Community mental health centers**, 4: 1113, 1114
- Community mental health services**, 4: 1103-1121
- Community Mental Health Services Act (N.Y.)**, 4: 1108
- Community organization**, 3: 1099; 6: 1900, 1945, 1947
- Community Research Associates**, 2: 605
- Companionate marriage**. *See* Trial marriage
- Comparative psychology**, 1: 205
- Compensation**, 4: 1161-2, 1164, 1407; 5: 1517, 1710; 6: 2019
- Compensation neuroses**, 3: 919; 5: 1498
- Competency**, 3: 908, 926
- Competition and competitiveness**, 1: 48, 127, 132; 2: 424, 536, 537, 542, 650, 651, 652; 3: 960, 972; 4: 1185, 1205, 1252, 1272; 5: 1548, 1549; 6: 2064
- Compulsions**, 1: 132, 189, 191, 192; 3: 811-812, 1046; 4: 1263, 1276, 1334, 1311, 1347, 1377-8, 1404; 5: 1602; 6: 1935, 1939
- Compulsory school attendance**, 5: 1818-19
- Conation**, 5: 1619
- Concentration camps**, 1: 322; 2: 467; 5: 1527; 6: 1981
- Conception (birth)**, 1: 337-54; 3: 1025, 1028, 1029; 6: 1963
- Concussion**, 1: 235-6, 238; 3: 1008
- Condensation**, 2: 503, 510; 4: 1159-60, 1164; 5: 1489
- Conditioned reflex and conditioning**, 1: 206; 3: 745, 1007; 4: 1398; 5: 1570, 1575
- Confession compulsion**, 2: 716
- Conformity**, 1: 111-12; 2: 387, 587; 6: 2041-2042, 2044
- Connecticut Society for Mental Hygiene**, 3: 1092
- Conscience**, 1: 292; 2: 402, 518, 626, 629; 4: 1246, 1247-9; 5: 1592
- See also* Superego
- Conscience and the State** (Cornell), 5: 1528
- Conscious processes**, 3: 1003; 4: 1352
- Constitutional factors**, 2: 355-66, 364-5; 4: 1479, 1481
- Consultation clinics**. *See* Child guidance clinics
- Consultation fees**. *See* Fees
- Contiguity (learning)**, 5: 1621
- Contraception**, 3: 617, 619, 650, 843; 5: 1535, 1536, 1539-40, 1541; 5: 1707; 6: 1874, 1877
- See also* Birth control
- Controls from Within** (Redl and Wineman), 5: 1812; 6: 1912
- Contusion**, 1: 236
- Convalescent leave**, 4: 1177
- Conversion and conversion hysteria**, 2: 723; 3: 818, 820, 1015, 1049-50; 4: 1157, 1163, 1312; 5: 1594, 1715
- religious, 5: 1752
- Convulsions**, 2: 722; 4: 1315
- See also* Epilepsy
- Convulsive shock therapy**. *See* Shock therapy
- Cooperative Research Program**. *See* U.S. Office of Education
- Coprophilia**, 5: 1697
- Cornell University (N.Y.)**, 1: 163; 3: 1081; 4: 1438; 6: 2037
- "Coronary" and coronary disease**, 1: 129, 133
- Corporal punishment (school)**, 5: 1812
- Corporate personality type**, 6: 2012
- Corporation management**, 6: 2035-6
- Corpus Hippocraticum** (Hippocrates), 3: 373
- Corpus luteum**, 3: 1017, 1024
- Correctional institutions and psychiatry**, 2: 367-80; 5: 1528
- See also* Prisons
- Cortisone**, 1: 228; 3: 772
- Costa Rica**, 6: 1983, 2052, 2057
- Council for Clinical Training**, 4: 1452
- Council for Exceptional Children**, 2: 676
- Council on Mental Health on Narcotic Addiction (A.M.A.)**, 4: 1284
- Council on Social Work Education**, 1: 275; 6: 1945, 1947
- Council of State Governments**, 3: 1100
- Counseling**, 1: 8, 49, 73, 74, 81-2, 121, 141, 259, 265; 3: 742, 891, 1085, 1089; 4: 1209, 1219; 5: 1499, 1579; 6: 1955, 2031, 2037, 2070, 2075, 2076
- See also* Marital counseling; School counseling; Vocational counseling
- Counseling and guidance training institutes (Nat. Defense Educ. Act)**, 2: 675
- Counterirritants**, 4: 1396
- County hospitals**, 4: 1135-6
- County medical societies**, 1: 176
- County welfare departments**, 4: 1177
- Courage to Be, The** (Tillich), 2: 592

Courts, 3: 905, 928; 5: 1526, 1581

See also Law

Courtship and engagement, 2: 381-95, 421, 648-9; 3: 823, 841, 981; 6: 1874, 2070

Couvade, 4: 1395

Coxsackie disease, 1: 243

Creativity, 1: 293; 2: 396-401, 588, 592, 667-9, 671, 672, 677, 678; 3: 759-60, 864, 872, 877, 881, 935; 5: 1581; 6: 2003, 2039, 2040

Cretinism, 3: 769; 4: 1192, 1193; 5: 1557, 1558

Crime and criminal responsibility, 1: 5-6, 48, 146; 2: 367, 402-14, 422, 604, 638, 708, 726, 727, 733; 3: 839, 893, 895, 907-12, 914-17, 928-9, 991-2; 4: 1121, 1213, 1253, 1335-6; 5: 1630, 1852 3; 6: 1867, 1921, 1937, 2011

"Criminal insane" units, 2: 375

Crippled children. *See* Children, handicapped

Crisis work and crises, 1: 292; 2: 522, 528, 531-2; 3: 1008, 1017; 4: 1253

"Crushes," 3: 754, 1013

Cryptomenorrhea, 3: 1030

Cuba, 1: 10

Cue (learning), 3: 930, 931, 934, 935

Cultural anthropology, 1: 326; 2: 418; 3: 980; 5: 1681

Cultural deprivation, 3: 873; 4: 1182; 5: 1804

Cultural factors and culture, 2: 415-26, 534, 565, 641; 3: 876; 4: 1242, 1341, 1353; 5: 1574; 6: 1896, 1897, 1898-9, 1903-5, 1918-19, 2005, 2026, 2043

Culturalist, 5: 1596

Cultural Patterns and Technical Change (Mead), 6: 1913

Culture shock, 4: 1240-41; 6: 1921

Curare, 4: 1336

"Cure," 6: 2077

Cuirens Rule, 3: 913, 916, 928

Current Anthropology, 6: 1899

"Curse, the," 3: 1012, 1027

Cushing's disease, 3: 772, 773; 4: 1375

Cushing Society. *See* Harvey Cushing Society

Cybernetics, 1: 329, 330-31; 2: 681; 5: 1763

Cycloid temperament, 4: 1468, 1479

Cyclothymia, 3: 1046; 4: 1469

Cynophobia, 5: 1485

Cyrano de Bergerac (Rostand), 2: 475

Dancing as therapy, 5: 1515; 6: 2053

Dartmouth College (N.H.), 3: 1081

Dasein, 2: 586-7

Dating, 1: 51, 55, 56; 2: 381, 384, 387, 552; 5: 1707; 6: 1874, 1934

See also Courtship; Steady dating

Day care centers and day hospitals, 1: 316; 4: 1113, 1130, 1135, 1302; 5: 1658, 1744; 6: 1994, 2052, 2054

Daydreams, 2: 502; 4: 1263

Deafness, 4: 1216, 1329; 5: 1501, 1505-8

Death, 1: 68, 256; 2: 427-50, 460, 525, 604, 611, 624, 627; 4: 1205, 1206, 1395, 1404, 1430; 5: 1499, 1500, 1516; 6: 2015, 2016, 2020, 2023

fear of, 2: 428, 431-2, 436, 438-9, 445, 448, 449, 460, 624

and funeral practices, 2: 434, 436-7, 448, 449

instinct, 2: 446; 3: 865

rate, 1: 44, 110, 132; 3: 1051, 1057; 4: 1204

Decomposition, 4: 1306

Defense mechanisms, 1: 291; 2: 461, 634;

6: 1911

See also Mental mechanisms

Defense Neuro-psychoses, *The* (S. Freud), 4: 1154

Deficiency diseases, 4: 1365

See also under name

Degenerative diseases, 4: 1367

Dehumanization, 1: 322

Déjà vu, 3: 1001, 1002; 4: 1421-5

Delinquency and delinquents, 1: 6, 59, 80, 148; 2: 408, 542, 604, 637, 638, 717; 3: 896, 900-901, 1095; 4: 1130, 1200, 1444, 1480

See also Juvenile delinquency

Delirium, 1: 235; 3: 738, 1037

tremens, 1: 193, 194; 5: 1662

Delusions, 1: 170; 2: 402, 422, 460; 3: 909, 995, 1044; 4: 1162, 1210, 1334, 1411, 1416-7; 5: 1567, 1654; 6: 1888

of grandeur and persecution, 4: 1412, 1414; 6: 1920

See also Paranoia

Demagoguery, 3: 996

Demand for living, 1: 293; 4: 1440

De Medicina (Celsus), 2: 373

Dementia, 3: 1044; 5: 1557

praecox, 5: 1574, 1782

Demerol, 4: 1276, 1278

Demographic Yearbook (1960) (U.N.), 4: 1204

Demographic Yearbook (1961) (U.N.), 6: 1912

Dendrites, 4: 1317, 1318

Denial, 2: 439, 440, 628, 629; 3: 819; 4: 1158, 1340, 1464, 1483; 5: 1499, 1710; 6: 1919, 1978, 1986

Dentistry, 5: 1659

Dependence, 1: 38, 40, 60, 69, 81, 110, 117, 133, 181, 291, 292, 295-6, 299; 2: 451-9, 488, 490, 536, 538, 541, 543, 597, 603; 3: 822, 826, 951, 952, 967-8, 974, 1002,

Dependence (Cont.)

1006, 1012, 1013; 4: 1205, 1206, 1222, 1248, 1271, 1334, 1338, 1342; 5: 1498, 1507, 1707, 1724; 6: 1870, 1871, 1993, 2023, 2028, 2042, 2070, 2071, 2072

Depersonalization, 3: 830; 6: 2068**Depression (economic)**, 1: 43, 215; 2: 604

Depression (psychic), 1: 123, 129, 136, 139, 140, 156, 228-9, 342, 343; 2: 422, 460-472, 519, 534, 603, 646, 703, 716, 717, 718; 3: 738, 762, 780, 781, 795, 812, 819, 825, 835, 879, 958-9, 960, 1017, 1020, 1021, 1030, 1035, 1044, 1045, 1049, 1082; 4: 1107, 1159, 1163, 1164, 1173, 1175, 1209, 1215, 1220, 1222, 1253, 1264, 1309, 1334, 1342, 1367, 1404, 1411, 1483; 5: 1499, 1565, 1567, 1656, 1821; 6: 1894, 1919-20, 1989, 2076

Depth psychology, 3: 914; 5: 1578

See also Psychoanalysis

De Senectute (Cicero), 1: 136**Desertion (marital)**, 1: 137; 2: 484, 485, 604**Destructiveness**. *See* Aggression**Deutsch, Albert, Crusader**. *See* Albert Deutsch**Deutsch Award and Memorial Foundation**.

See Albert Deutsch Award

Developmental stages, 1: 58, 281**Devereux Foundation**, 4: 1181**Deviant behavior**, 4: 1213, 1218, 1222, 1335; 6: 1936**Dexedrine**, 2: 470, 501, 508; 5: 1656**Dextro amphetamine**, 5: 1656

Diabetes, 1: 159, 324, 337; 3: 769, 772; 4: 1365, 1367, 1369, 1375, 1376; 5: 1495, 1499

See Juvenile diabetes

Diagnosis and diagnostic testing, 1: 265; 3: 1041; 5: 1564, 1565, 1608-17**Diagnostic and Statistical Manual (A.P.A.)**, 3: 1034**Dianetics**, 1: 331**Dictionary of Psychology (Warren)**, 2: 547**Dieting**, 4: 1381, 1382**"Difficult" persons**, 3: 951**Digitalis**, 4: 1408**Dilantin**, 2: 570, 578**Dilaudid**, 4: 1279**Dionysian temperament**, 2: 365**Diphenylhydantoin**, 2: 570, 578**Diphtheria**, 1: 289; 4: 1192**Directive therapies**, 5: 1735**Directory of American Psychological Services 1960 (Amer. Bd. for P. S.)**, 1: 223**Directory of Vocational Counseling Services (Amer. Bd. on Professional Standards in Vocational Counseling)**, 1: 223**Dirty words**, 5: 1698

Discipline, 1: 92, 145, 150, 306; 2: 453, 630; 3: 960, 1083; 4: 1442-3; 6: 1901

See also Self-discipline

Discrimination, 5: 1546, 1547, 1555; 6: 1934**Disease choice**, 5: 1714

See also Choice of neurosis

Disorders, 3: 1031-9

See Illness and health, family in, 2: 596-623

Displacement, 2: 503, 510; 4: 1156-7, 1159, 1164; 5: 1489; 6: 2030, 2031

Dissociation, 3: 741, 820, 821, 829, 990, 995, 997, 1045, 1049; 4: 1158, 1162, 1164, 1263, 1342; 6: 1892

Distal index (somatotype), 2: 359**"Distributed practice" (study)**, 3: 935**"Distributive analysis"**, 5: 1734**Disturbed children**. *See* Children, emotional disorders**"Disturbed wards"**, 2: 479**Disulfiram**, 1: 195-6; 5: 1662**Divination**, 4: 1425

Divorce, 1: 64, 67, 137-8; 2: 382-3, 391, 394, 395, 542, 604, 605; 3: 917, 971, 974, 977, 981; 4: 1416; 6: 1873, 1874, 1967, 1969, 1982, 2009, 2019

emotional problems, 2: 483-97

Divorcée Anonymous, Inc., 2: 495**Dr. Jekyll and Mr. Hyde (Stevenson)**, 3: 821**Document authentication**, 2: 694, 695**Dominican Republic**, 1: 30-**Don Juan character**, 1: 282**"Double bind" communication**, 6: 1901**Double standard (sexual morality)**, 2: 384**Draft Act (hospitalization of mentally ill)**, 3: 780, 781**"Drag"**, 5: 1849**Drama as therapy**, 5: 1515

See also Psychodrama

Dream interpretation and dreams, 2: 498-512, 518, 551, 635-6; 3: 840, 1002; 4: 1159, 1263, 1423-4, 1431, 1432-4, 1483; 5: 1489, 1506, 1586, 1588, 1840; 6: 1890, 1905, 2003, 2005

Dream rhythm, 6: 1895

Dream-sleep cycle, 2: 498-9, 503, 504, 505, 508, 512

Drinking. *See* Alcoholics**Drive (sing.)**, 4: 1258**Drives**. *See* Instinct and instinctual drives

Drug addiction, 1: 48; 2: 422, 542, 553; 3: 899, 1082; 4: 1109, 1111, 1119, 1265, 1292, 1295, 1296, 1337, 1338, 1406; 5: 1578, 1661, 1730; 6: 1921, 1937

See also Addiction; Narcotic addiction

- Drug therapy, 1: 5, 123, 210, 263; 2: 520, 544, 631; 3: 962, 991, 999, 1005, 1008, 1031; 4: 1111, 1219, 1339, 1483, 1491; 5: 1565, 1569, 1595, 1745-6; 6: 2079
See also Psychopharmacology; Sedative drugs; Tranquilizing drugs; and under name of drug
- D.T.'s. *See* Delirium tremens
- "Due process," 3: 921
- Duke University Parapsychology Laboratory, 1: 168; 4: 1424, 1428, 1433
- Durham Decision, 2: 411, 513-14; 3: 911-12, 913, 916; 4: 1336; 5: 1578
- Dwarfism, 2: 364
- "Dyke," 3: 747
- Dynamic psychiatry, 1: 314; 2: 586, 637, 687; 3: 742, 827, 851, 856, 1040, 1041; 4: 1107, 1256, 1263, 1470; 5: 1577-9, 1591, 1595, 1596, 1621, 1665-7; 6: 1900
- Dynamics of Aging* (E. S. Smith), 3: 969
- Dysmenorrhea, 3: 1030
- Dysplasia, 2: 360
- Early childhood. *See* Childhood
- Early diagnosis and treatment, 3: 825; 4: 1103, 1110, 1112, 1142, 1144, 1174, 1175, 1229; 5: 1563, 1565; 6: 1922, 1913, 2052, 2053
- Early marriage, 1: 64; 2: 290, 487, 495; 3: 974; 6: 1871-2, 2069
- Early Marriage* (film), 5: 1845
- Echinococcus, 1: 243
- Echolalia, 4: 1196
- Eclecticism, 5: 1570
- Ectomorphy, 2: 357-8; 4: 1468-9
- Education and educators, 1: 259; 3: 948, 1060-62, 1067, 1078, 1080, 1089, 1096, 1097; 6: 1933, 1935, 1936, 2056, 2072
- Educational Testing Service, 3: 944
- E.E.G. *See* Electroencephalography
- "Effects Upon Children of Their Mothers' Outside Employment, The" (Mac-coby), 3: 970
- Effort and effort syndrome, 1: 131; 4: 1262
- Ego and ego identity, 1: 75-6, 79; 2: 508, 515-20, 547, 586, 636; 3: 712, 852, 857, 864, 865, 866, 868, 870, 1069; 4: 1154, 1155, 1157, 1160, 1246, 1249, 1264, 1472, 1473, 1479; 5: 1486, 1490, 1491, 1590, 1592, 1752; 6: 1975, 2002, 2003
- defenses. *See* Mental mechanisms
- ideal, 4: 1246, 1248, 1250
- processes, 4: 1249
- psychology, 5: 1592
- states, 2: 516-17, 519, 520
- strength, 2: 518-19, 543; 3: 796, 827; 6: 1913, 1980
- Ego and the Mechanisms of Defense, The* (A. Freud), 3: 865
- Egocentricity, 4: 1407
- Egypt (ancient), 1: 281; 2: 682; 3: 803; 4: 1277; 5: 1523
- Eidetic images, 3: 1000
- Eighteenth Amendment, 1: 203-4
- Electroconvulsive therapy. *See* Shock therapy
- Electroencephalography, 1: 229; 2: 403, 498, 499, 500, 572, 582; 4: 1328; 6: 1886, 1891, 1892, 1893
- Electromyogram, 4: 1328
- Electroshock therapy. *See* Shock therapy
- Elgin Checklist of Fundamental Psychotic Behavior Reactions (Wittman), 2: 362
- Elgin State Hospital (Ill.), 2: 362
- Elimination disturbances, 1: 291, 303; 4: 1210
- Elopement, 2: 391
- Embolism, 1: 247
- E.M.G. *See* Electromyogram
- Emotional crises and disturbances, 2: 488, 521-32, 545, 547-57, 548, 716; 3: 829, 863, 895, 900, 914, 919, 955, 994, 1000, 1007, 1009; 4: 1207, 1263-4, 1326, 1358, 1411, 1463, 1466; 5: 1523, 1563, 1587, 1620; 6: 1975, 1977, 2001, 2003, 2015-2016
- Emotional maturity, 1: 24, 80; 2: 533-46, 4: 1337; 6: 1868, 1871, 1977
- Emotional Problems and the Therapeutic Role of Insight, The* (Zilboorg), 3: 857
- Emotionally disturbed children. *See* Children, emotional disorders
- Emotion and emotions, 2: 547-57
- Empathy, 3: 827; 4: 1466
- Employer-employee relation, 6: 2033
- Encephalitis, 1: 243, 244; 2: 575; 3: 1037; 4: 1183; 5: 1669; 6: 1892
- Encopresis, 1: 307
- Encyclopedia of Mental Health*, 2: 480, 482
- Endocrine disorders and endocrines, 3: 765-767, 1028; 6: 1962
- Endomorphy, 2: 357-8, 361, 362, 365; 4: 1468
- Enfant terrible*, 4: 1441
- Engagement (courtship), 2: 381-95; 5: 1845
- England, 1: 26; 2: 565, 566, 680, 710, 711; 3: 740, 748, 762, 777-8, 798, 806-7, 909-910, 915, 1032, 4: 1105, 1112, 1113, 1238, 1277, 1439, 1441, 1445; 5: 1571, 1572, 1621, 1671, 1741, 1787; 6: 1897, 1901, 1910, 1916, 1983, 1995, 1996
- English East India Company, 4: 1277
- Engram, 3: 998, 999, 1004, 1006, 1008, 1009
- Enuresis, 1: 294, 307; 2: 726; 3: 1050; 6: 1892-3

- Environment and environmental therapy, 1: 279-80; 3: 1071-2, 1075; 4: 1194, 1213, 1215, 1216, 1232; 5: 1553, 1569, 1596; 6: 1913, 1931, 2055
 -heredity problem, 1: 98, 299-300; 2: 596-7, 637; 6: 1973
See also Heredity
See also Social environment
 Enzymatic disturbances, 4: 1375
 Eonism, 5: 1697
 Epidemiology, 1: 259; 2: 558-68; 4: 1228, 1294; 5: 1559; 6: 1901-6
 Epi-Hab L.A. (Los Angeles), 2: 580-81
 Epilepsy, 1: 248; 2: 569-82, 726, 731; 3: 737, 819; 4: 1109, 1196, 1324, 1327, 1408; 5: 1495, 1506, 1523; 6: 1870, 1893
Epilepsy and the Law (Barrow and Fabing), 2: 577
 Epilepsy Information Center, Inc., 2: 580
 Epinephrine, 1: 233; 3: 768
 Equanil, 5: 1655
 Erogenous zones, 6: 1876
 Eros, 2: 446; 3: 865; 5: 1591
 "Escape from freedom," 6: 2009
 Escape maneuvers. *See* Mental mechanisms
 Escape panic. *See* Panic
 E.S.P. *See* Extrasensory perception
 Estrogens and estrus, 3: 768, 1024, 1027
 Ethnic origin. *See* under name of country
 Ethnology, 6: 1899
 Ethology, 3: 866, 869; 6: 2006
 Ethosuximide, 2: 570
 Eugenic sterilization and eugenics, 1: 117; 2: 734; 4: 1189; 6: 1970-74
 Eunuch, 3: 837-8
 Euphoria, 4: 1406
 Europe, 3: 939; 4: 1428; 5: 1666, 1734, 1746, 1758, 1805
See also under name of country
 Euthanasia, 4: 1186
 "Evil intent," 2: 410
 Evocative therapies, 5: 1733-5
 Evolutionary concept, 5: 1588; 6: 1897, 1898
 Examination panic, 3: 1081-2; 5: 1804-5
 Exceptional children, 2: 676; 4: 1202
 "Ex-convict," 2: 378
 Exhaustion syndrome, 4: 1307, 1308, 1309; 5: 1669
 Exhibitionism, 1: 170; 2: 406; 5: 1487, 1697, 1848-9, 1851, 1852
Existence (Boss), 2: 593
 Existential therapy and existentialism, 2: 448, 583-95; 3: 744; 4: 1340; 5: 1571, 1578, 1758
 Exophthalmic goiter, 3: 769
 Ex-patient clubs, 5: 1745
 Experimental human psychopathology, 5: 1840
 Experimental psychology, 3: 866, 1076; 4: 1341; 5: 1619; 6: 1928
 Expert testimony, 3: 918-20, 922-3, 926, 928, 959
 Expiation. *See* Atonement
Exploration of the Inner World (Boisen), 5: 1753
 Extramarital relations. *See* Marital infidelity
 Extrasensory perception, 4: 1421, 1426, 1429
 Extroverts, 2: 362; 4: 1340, 1468
 Eye and eyesight, 4: 1462
 Facial deformity, 5: 1501, 1502, 1505
 Factor analysis (personality), 4: 1471-2, 5: 1621
Facts of Life and Love (Duvall), 3: 968
 Failure, fear of, 6: 2050, 2065
 "Fairies," 3: 747
 Faith healers and faith healing, 3: 824; 4: 1401, 1433-4; 5: 1728, 1730; 6: 2053
 Falling in love, 5: 1703-5, 1843
Falling Sickness, The (Temkin), 2: 570
 Family and family life, 1: 101-2, 117-19; 2: 492, 497, 596-623, 651-2, 660; 3: 844-846, 895-6, 968, 970, 987, 1069, 1074, 1077, 1078, 1089; 4: 1142, 1172-5, 1176, 1193, 1199-1200, 1219-22, 1236-8, 1241-3, 1271, 1335, 1368, 1373-5, 1380, 1444, 1445-7; 5: 1492, 1493, 1505, 1519, 1540, 1542, 1749, 1760, 1764-5, 1834; 6: 1867-8, 1879, 1911, 1913, 1916, 1917, 1918, 1920, 1921, 1924, 1926, 1929, 1931, 1933, 1936, 1938, 1981, 1982, 2020-21, 2026, 2031, 2032, 2051, 2065, 2072, 2073
 education, 3: 848; 5: 1562
 psychotherapy and treatment, 2: 612-23, 708; 3: 744, 775, 903, 906; 4: 1482; 5: 1740, 1744
See also Father-son relation; Mother-child relation; Parent-child relation; Parenthood
 Family Service Association of America, 2: 497, 623; 6: 2079
 Family service societies, 6: 1942
 Famine, 5: 1532, 1540
 Fantasies and fantasy, 2: 502, 634; 3: 807, 809-10, 851, 857, 1014; 4: 1218, 1245, 1263; 5: 1506, 1511, 1517, 1586, 1589; 6: 1987
Far Away and Long Ago (Hudson), 2: 440
 Far East, 2: 610; 4: 1277
See also under name of country
 Father of medicine. *See* Hippocrates, in Name Index
 Father-son relation, 1: 50, 57-8; 4: 1443-4; 6: 2044

- Fats**, 4: 1356, 1359
Fear, 1: 79, 81, 212, 296; 2: 547-51, 553-7, 624-31; 3: 751-2, 757, 995; 5: 1485, 1496, 1549, 1567, 1584; 6: 2059, 2077
Federal Association for Epilepsy, 2: 579
Federal Bureau of Prisons, 1: 368; 3: 927
Federal Security Administration, 3: 1098
Federation of American Societies for Experimental Biology, 5: 1632
Feeble-mindedness, 2: 542; 3: 1001; 6: 1870
 See also Mental retardation
Fees, 4: 1116-7; 5: 1582, 1597, 1613
Fellatio, 5: 1848
Female characteristics, 3: 765, 771
Female hormones, 3: 765-7, 868
Feminine role, 1: 116, 118-19, 337, 338, 346, 351; 2: 495, 648, 650, 651, 655; 3: 747, 823, 842, 1012, 1014, 1022-3, 1025, 1074; 4: 1207, 1394; 5: 1694; 6: 1867, 1877, 2023, 2034, 2073
Fernald State School. *See* Walter E. Fernald State School
Fertility, 3: 769; 5: 1538
Fetishism, 1: 1697, 1852, 1859
Fever, 4: 1372, 1408
Field theory (personality), 5: 1621
Fifth Mental Measurement Yearbook, 5: 1606
Fight-flight reaction. *See* Flight-flight reaction
Finland, 1: 10; 6: 1983
Fire setting, 1: 304; 3: 899; 5: 1697
 See also Pyromania
First Five Minutes (Pittenger), 1: 333
First International Congress of Mental Hygiene, 6: 2060
First love, 3: 954-5
First Opium War, 4: 1277
Five-day hospitals, 4: 1136
Fixations, 1: 29; 3: 804
Flexibility, 1: 113, 116, 117; 2: 537, 668, 829, 1069-70; 4: 1205, 1206, 1351
Flexion reflex, 4: 1321, 1390
Flexner Report, 3: 1095
Flight-flight reaction, 2: 624, 626, 628; 3: 768; 6: 1979
Flight into health, 5: 1603
Flushing, 3: 772, 1017, 1021, 1022
Folie à deux, 4: 1418-19
Folk medicine, 6: 1905, 2053
Follicle-stimulating hormone, 3: 768
Food and Agriculture Organization (U.N.), 4: 1369
Food and Drug Administration, 2: 816; 4: 1305; 5: 1558
Food and Nutrition Board (Nat. Research Council), 4: 1363
Food fads and habits, 4: 1360-62, 1370
Foods. *See* Nutrition
Forbes's Law (Mass. Gen. Hosp.), 3: 771
Forbidden Games (film), 2: 440
Foreknowledge. *See* Precognition
Forensic psychology, 2: 688
Forged, Anonymous and Suspect Documents (Quirke), 2: 696
Forgetting, unconscious, 1: 158; 4: 1263
Formosa, 2: 565
Fort Worth Hospital (Texas), 4: 1123, 1127, 1283
Foster care, 1: 73, 74, 79, 106; 3: 864
Foundations' Fund for Research in Psi, 5: 1766-67
France, 1: 30, 181, 183, 187; 2: 688, 699; 3: 740, 884; 4: 1105, 1188, 1236, 1277; 5: 1571, 1572, 1573, 1621, 1651, 1635, 1671; 6: 1895, 1983
Franco-Prussian War, 4: 1213
Free association, 2: 510, 635; 3: 803, 824, 999, 1004, 1005; 4: 1160, 1164, 1344, 1483; 5: 1596-8, 1733, 1749; 6: 2005
Freud and Religion (Zilboorg), 5: 1758
Freud, Sigmund, 2: 632-42; 5: 1758
 See also in Name Index
Frigidity, 1: 339; 2: 643-60; 3: 757, 823, 839, 844, 981; 4: 1342; 5: 1691, 1853; 6: 1877, 1878, 1879, 1963, 1964
Frottage, 5: 1849
"Fruit," 3: 747
Frustrations, 1: 145, 146, 151; 2: 556, 630; 4: 1194, 1195, 1196, 1216, 1479; 5: 1619; 6: 1948, 1975, 1976, 2015, 2034, 2066
F.S.H. *See* Follicle-stimulating hormone
"Fugitives of the unconscious," 2: 691
Fugue states, 3: 821, 830, 1008; 4: 1158; 6: 1892
Galactosemia, 1: 228, 245; 4: 1191
Gallows humor. *See* Humor
Gamblers Anonymous and gambling, 2: 542; 3: 743
Gang psychology and gangs, 1: 63, 64, 66; 2: 403; 3: 896-7, 901-2, 906, 931, 993; 4: 1200
Gangsters, 4: 1278
Ganser syndrome, 4: 1336
G.A.P. *See* Group for the Advancement of Psychiatry
Gargoylism, 4: 1193
Gastric ulcers. *See* Ulcers
"Gay" life, 3: 747, 753, 754, 761
Gender role, 5: 1686
General hospitals, 1: 261; 3: 777; 4: 1105, 1110, 1112-13, 1126
 See also Hospitalization
General paresis. *See* Paresis; Syphilis

- General semantics**, 3: 744
- Genetic factors and genetics**, 1: 259, 324; 2: 568, 596-7, 697, 724, 726, 730; 4: 1335, 1475; 5: 1588-90, 1760, 1762, 1764
- Genetic Studies of Genius** (Terman), 2: 663
- Genital phase/stage and genitality**, 1: 281, 282, 291; 5: 1685-6
- Genius**, 2: 661-6, 668; 3: 853, 876, 889, 1078; 5: 1580
- Genius, Insanity and Fame** (Lange-Eichbaum), 5: 1523
- Genocide**, 5: 1546
- Geriatrics**, 4: 1109, 1112
See also Aged and aging
- German measles**, 1: 19, 25; 4: 1183
- Germany**, 2: 688, 699; 4: 1277, 1444; 5: 1571, 1572, 1574, 1606, 1621, 1625, 1812; 6: 1908, 1983, 1984, 2010
- Gesell development schedule**, 3: 890
- Gestalt psychology**, 3: 685, 702, 744, 931; 5: 1621
- Gestures**, 3: 679, 687
- Giantism and gigantism**, 2: 364; 3: 769
- Gifted child and giftedness**, 1: 65-6; 2: 667-678; 3: 877-8, 886, 889, 939, 1078; 4: 1473; 5: 1800-1801
- The Gifted: Educational Resources** (Sargent), 2: 675
- Glaucoma**, 4: 1324
- Glia cells**, 4: 1317
- Glucostat theory**, 4: 1359-60
- Glueck scales**, 3: 901
- Glutamine**, 1: 231
- God and Freud** (Gross), 5: 1759
- Goethe prize**, 2: 642
- Going steady**. *See* Steady dating
- Golden Age centers**, 1: 161
- Gonadotropins and gonads**, 1: 37; 3: 1024
- "Good character"**, 1: 276-7
- "Good mothering"**, 1: 75
- Goodrich Act** (Michigan), 5: 1862
- "Good time"** (prison), 2: 370
- Goodwill Industries of America**, 6: 2079
- "Goosing"**, 5: 1849
- Gout**, 4: 1365
- Governors' Conference on Mental Health** (1961), 4: 1120
- Graafian follicles**, 3: 768
- Grand mal**, 2: 569, 571, 572, 576, 579
- Grandparents**, 4: 1447; 6: 1981
- Graphodyne**, 2: 686, 687
- Graphology**, 2: 679-702; 5: 1506
- Graphology and the Psychology of Handwriting** (Downey), 2: 687
- Gray Ladies** (Amer. Red Cross), 1: 187
- Great Britain**, 2: 437, 568, 609; 3: 874, 887; 4: 1120, 1277; 5: 1722, 1812; 6: 1910, 1922, 2056
- Greece (ancient)**, 1: 30; 2: 373, 399, 585, 664, 679, 682, 684; 3: 749, 803; 4: 1187, 1334, 1345, 1467, 1469; 5: 1573, 1688, 1983, 1984
- Grief and grief work**, 1: 68, 78; 2: 437, 441, 456, 461, 545, 546, 548, 703-6, 717; 3: 855, 1035; 4: 1450-51; 6: 1955, 2014, 2016-17, 2019, 2022, 2025
- Group for the Advancement of Psychiatry**, 3: 1097; 4: 1195; 5: 1854, 1865; 6: 2036
- Comm. on Religion and Psychiatry**, 5: 1756
- Group Health Insurance, Inc. (N.Y.C.)**, 4: 1149
- Group identification**, 2: 404-5, 707; 5: 1708
- Group processes**, 4: 1213; 5: 1511
- Group psychotherapy**, 1: 81, 176, 178, 265; 2: 373, 544, 609, 620, 638, 707-15; 3: 742, 744, 761, 762, 992, 993; 4: 1111, 1173, 1219, 1222, 1228, 1344-5, 1482; 5: 1515, 1571, 1574, 1730, 1732, 1772, 1854; 6: 1905, 1913, 1939-40, 1945, 1998
- Growth hormone**, 1: 37; 3: 768
- Guatemala**, 6: 1983
- Guilt feelings**, 1: 62, 68, 74, 79, 80, 81, 82, 128, 292; 2: 716-18; 3: 841, 995; 4: 1246, 1248, 1450, 1451; 5: 1496, 1549, 1752-3; 6: 1920, 1963, 1980-91, 2005, 2009, 2016, 2047
- Gynecology**, 1: 399; 3: 984, 1029
- Gynic endowment**, 2: 360, 361
- Habeas corpus**, 3: 783; 4: 1171
- Habituation**, 4: 1276, 1396
- Haiti**, 3: 991
- Halfway houses**, 4: 1114-15, 1135; 5: 1740, 1744
- Hallucinations**, 1: 193-4, 232, 235, 246, 322; 2: 370, 460, 462, 498, 502, 506, 569; 3: 803, 807; 4: 1159, 1316, 1317, 1334, 1411, 1417, 1464; 5: 1567, 1654, 1837; 6: 1888, 1979, 2005
- Hallucinogenic drugs**, 5: 1796
- Handbook of Aging and the Individual** (Birren, ed.), 1: 154
- Handbook of Social Psychology** (n.a.), 6: 1927
- Handedness**, 2: 691, 697, 698, 700-702
- Handicapped and mental health**, 5: 1501-10
 children. *See* Children, handicapped
See also Physical handicaps
- Handsome Lake Movement**, 6: 1905
- Handwriting**. *See* Graphology
- Happy Family, The** (Levy and Monroe), 3: 968
- Haptic phase**, 5: 1682

- Harelip, 2: 360**
Harrison Narcotic Act (1914), 4: 1279
Harvard University, 2: 436, 447, 687; 3: 771, 801, 805, 1081, 1084, 1086, 1091; 4: 1392, 1393, 1470, 1484; 5: 1552, 1620; 6: 2014
Harvey Cushing Society, 4: 1331
Hate, 1: 6; 2: 545; 3: 994, 995; 4: 1245; 5: 1524, 1549
Headaches, 2: 555, 582, 719-23; 4: 1327, 1328; 5: 1715
See also Migraine
Healers. See Faith healers
Health Amendments Act (1956), 4: 1300
Health and Human Behavior (publication), 6: 1899
Health and illness. See Illness and health, family in, 2: 596-623
Health Education Division (A.M.A.), 1: 274
Health insurance, 4: 1117, 1141, 1146-53, 1174
Health Insurance Plan of Greater N.Y., 4: 1149
Healy Lecture Completion test, 5: 1609
Hearing and hearing disturbances, 3: 1050; 4: 1208, 1328, 1459
See also Deafness
Heart disease and heart failure, 1: 18, 228, 337; 4: 1408
Hebephrenia, 2: 363, 519; 3: 1044
Hepatitis, 1: 231
"Hereditary taint," 3: 724
Heredity, 1: 97-8; 2: 567, 596, 724-35; 4: 1189, 1373, 1474; 5: 1788, 1831; 6: 1970
-environment interaction, 1: 98, 299-300; 2: 596-7, 637; 3: 873, 932, 1077; 4: 1182, 1270-71, 1374
Hermann Poltergeist Case, 4: 1424
Hermaphrodite, 5: 1680, 1687, 1849
Heroin, 4: 1276, 1278, 1279, 1280, 1396
H.E.W. See U.S. Department of Health, Education, and Welfare
Heywood Broun Award Committee, 2: 476
High blood pressure. See Hypertension
High school, 5: 1813-17
High standard of living, 5: 1625
Hill Burton Act (1946), 4: 1140
H.I.P. See Health Insurance Plan of Greater N.Y.
Hirsutism, 3: 770, 772
History of Medicine in the World War, 4: 1214
History of psychiatry, 3: 737-46, 1101-2
History of Public Welfare in N.Y. State (A. Deutsch et al.), 2: 477
History of treatment of mental disorders, 3: 737-46
See also History of psychiatry
Hobbies, 1: 141; 4: 1344; 5: 1515; 6: 2066
Hogg Foundation for Mental Health (Austin, Tex.), 5: 1766
Holidays, 5: 1512, 1513
Holland. See Netherlands
Homeostasis, 2: 521, 522; 4: 1260
Homesickness, 2: 703
Homicide, 2: 405, 422, 542, 602; 3: 915
"Homo," 3: 747
Homosexuality, 1: 62, 141, 192, 292; 2: 371, 372, 406, 654, 726, 727, 731-2; 3: 747-764, 771, 836, 837, 953, 981; 4: 1334, 1410, 1417; 5: 1700-1701, 1831, 1852, 1863; 6: 1870, 1871, 1876, 1881, 1904, 2009, 2064
Hookworm. See Ancylostomiasis
Hopelessness, 2: 447, 548
Hormones and behavior, 3: 765-74, 846, 847, 1021, 1022
Hospital Bicêtre (Paris), 4: 1345
Hospital for Sick Children (London), 1: 313
Hospitalization and hospitals, 1: 123; 2: 560, 562, 609, 610; 3: 775-85, 959, 961, 1055, 1056, 1093, 1099; 4: 1103, 1166-1177, 1210, 1220; 5: 1740-44; 1834-5
chaplains, 4: 1453
first admissions, 4: 1138-9, 1172, 1210, 1235; 6: 1915
insurance, 4: 1133-4, 1140-42
overcrowding, 4: 1124, 1128; 6: 2053
superintendents, 6: 1997, 1998
See also Commitment; Mental hospitals; Psychiatric hospitals; Veterans hospitals; Voluntary hospitals
Hostility, 1: 66, 68, 185; 2: 615, 626, 632, 718; 3: 747, 770, 788, 794, 844, 995, 1014; 4: 1158, 1159, 1210, 1211, 1278, 1409, 1416, 1464; 5: 1509, 1517, 1545, 1546, 1581; 6: 1987, 2014, 2016, 2030, 2042, 2043
Hot flashes. See Flushing
How Much Affection (film), 5: 1845
Hudson River State Hospital (N.Y.), 6: 1994
Human Beginnings (film), 5: 1845
Human Betterment Association of America, 6: 1974
Human engineering, 5: 1630, 1631
Human Growth (film), 5: 1845
Human Organization (publication), 6: 1899
Human Personality and its Survival of Bodily Death (Myers), 2: 437
Humor, 2: 635; 3: 752, 786-99; 5: 1588, 1591
Humors, 3: 738; 4: 1337, 1468
Hungary, 2: 686; 6: 1983
Hunger. See Appetite

- Huntington's chorea, 1: 243; 2: 567
 Hydrocephaly, 4: 1191, 1192
 Hydrophobia, 5: 1485
Hyperemesis gravidarum, 1: 18
 Hypermenorrhea, 3: 1030
 Hypermnnesia, 3: 999
 Hypertension, 1: 18, 19, 134, 229; 2: 555, 722; 3: 1017, 1045; 4: 1264, 1334, 1375, 1376, 1408; 5: 1712, 1719; 6: 1980
 Hyperthyroidism, 3: 770, 771; 5: 1172
 Hypnosis, 1: 251, 354; 2: 508, 518, 520, 633, 635, 639, 659, 706; 3: 800-817, 819, 997, 1005, 1008; 4: 1265, 1344, 1381, 1395, 1402, 1425, 1483; 5: 1735, 1797, 1839; 6: 1891, 1953-4, 2001, 2005
Hypnosis and Related States (Brenman and Gill), 3: 816
Hypnotherapy in Clinical Psychiatry (Rosen), 3: 816
 Hypnotism. *See* Hypnosis
Hypnotism: An Objective Study in Suggestibility (Weitzenhoffer), 3: 816
 Hypochondriasis, 4: 1413, 1463; 5: 1498
 Hypoglycemia, 1: 245
 Hypomania, 3: 958; 4: 1335
 Hypotensives, 1: 244
 Hypothalamus, 2: 550; 3: 868, 1025; 4: 1316, 1339; 5: 1571
 Hypothyroidism, 6: 1968
 Hypoxemia, 1: 231
 Hysterectomy, 2: 531; 3: 810, 1020
 Hysteria and hysterical character, 1: 282, 324; 2: 542, 633, 634, 639; 3: 790, 818-826, 830, 990, 1046; 4: 1336, 1337, 1479; 6: 1903
See Mass hysteria
- Iceland, 6: 1983
 Id, 2: 508, 516-9, 586; 3: 742, 864-8, 1069; 4: 1155, 1156, 1246; 5: 1486, 1491, 1592; 6: 2002, 2003
 Idealism and idealization, 4: 1160; 6: 2016, 2023, 2066
 Identification, 1: 188, 279, 291, 292, 295; 2: 703; 3: 827, 836; 4: 1160, 1164, 1245, 1247, 1263, 1353, 1466, 1475; 5: 1515, 1529; 6: 1913, 1989, 2028, 2038, 2066
 negative, 4: 1160
 with aggressor, 3: 752
 with parent, 1: 46-7, 59, 68, 291; 2: 455, 466-7, 491, 494, 537; 3: 750, 752, 758, 827, 1013; 4: 1155, 1160
 Identity and identity loss, 3: 819, 821, 827-833, 973, 1008, 1069, 1077-8, 1081, 1083; 4: 1242; 5: 1487, 1517; 6: 1913, 2027, 2028, 2031, 2043, 2071, 2074
Identity and the Life Cycle (Erikson), 3: 1083
 Ideograms, 3: 682, 683, 684
Ideographia, 2: 684
 Idiocy, 2: 662; 3: 890, 908, 909; 4: 1187, 1188; 6: 1971
 "Imaginary symptoms," 5: 1755
 Imbecility, 3: 890; 4: 1481
 Imipramine, 5: 1656
 Immaturity, 1: 181, 284; 2: 455, 516, 536, 541; 3: 786, 796, 864, 1046; 4: 1217, 1338; 6: 2003, 2071, 2074
 Immigration, 6: 1921
See also Mobility
 Immortality, attitude toward, 2: 430, 437-438; 4: 1231
 Immunization, 1: 289; 4: 1192
 Impotence, 1: 338; 2: 485, 643, 646, 656; 3: 756-7, 771, 834-49, 981; 4: 1312; 5: 1691; 6: 1877, 1878, 1879, 1963, 1964
 "Impressions of Personality as a Function of Marital Conflict" (Preston *et al.*), 3: 973
 Imprinting, 1: 210; 2: 597; 3: 866, 868; 5: 1683, 1763
 Impulses, 4: 1155, 1245; 5: 1486, 1586, 6: 2003
 Impulsiveness, 1: 80, 284; 3: 961; 4: 1217, 1482
 Inadequacy, sense of, 1: 57, 80, 189, 190; 2: 402, 405, 507, 602, 624, 645, 659; 3: 835, 1081; 4: 1360; 5: 1734; 6: 1918, 2016, 2022, 2028, 2035, 2046
 Incentive plans and programs, 6: 2030, 2033
 Incest taboos and fantasies, 2: 597; 3: 820, 823; 5: 1692, 1701, 1702, 1849
 Incompetency, 3: 920-21
 Incomplete Sentences test, 4: 1477
 Incontinence, 1: 167
 Incorporation, 4: 1248, 1358
See also Introjection
 Independence, 1: 38, 45, 57, 59, 60, 61, 110, 117, 293, 306; 2: 391, 451, 452, 453, 455, 459, 493, 535, 538; 3: 1013, 1037; 5: 1497, 1561; 6: 2014, 2018, 2023, 2042, 2065
 India, 2: 424; 3: 874, 887; 4: 1277, 1324, 1369; 5: 1538, 1582; 6: 1902, 2053
 Indoctrination, 1: 252, 253, 256; 4: 1251
 Industrialization, 4: 1474; 6: 1910, 1913, 1981, 2007-2009, 2063
 Industrial psychiatry, 1: 263; 5: 1577; 6: 2036, 2037
 Industrial revolution, 6: 1908, 1909
Ineffective Soldiers, The (Ginzberg), 4: 1224
 Infancy and infants, 1: 289-90; 4: 1327, 1339; 5: 1588, 1678, 1686

- Infancy and infants (Cont.)**
 emotional needs, 2: 537
 fantasies, 4: 1405
 hospitalization, 2: 603
 play, 5: 1518-19
 rejection, 3: 741
 sexuality, 1: 131; 2: 635
 tensions, 1: 303
 testing, 3: 887-8, 890; 4: 1161-2
- Infanticide**, 4: 1187; 5: 1531
- Infantile autism**, 1: 308; 5: 1788, 1792, 1794
- Infantile paralysis**, 1: 289
See also Poliomyelitis
- Infatuation**, 2: 382, 391; 3: 1013; 6: 1882
- Infectious mononucleosis**, 1: 243
- Inferiority complex**, 1: 58, 136, 292; 3: 844, 944; 4: 1161, 1196, 1340, 1407; 6: 1966
- Infertility**, 3: 981
See also Sterility
- Infidelity**. *See* Marital infidelity
- Information theory**, 1: 329, 330; 5: 1763
- Informed Heart: Autonomy in a Mass Age**.
The (Rettelheim), 5: 1527
- Inkblot test**. *See* Rorschach test
- In-laws**, 3: 967-8; 4: 1447
- Inquisition, The**, 5: 1782
- "Insane asylums,"** 5: 1527
- Insanity**, 2: 409-10, 485, 513-14; 3: 908, 909, 913-14, 921-2, 1039; 4: 1104, 1334; 5: 1523, 1730
- Insect behavior**, 3: 860, 867
- Insecurity**, 3: 753, 994; 4: 1368; 5: 1552
- Insight**, 2: 556; 3: 850-58, 878; 4: 1483; 6: 1912, 1993
- Insomnia**, 1: 123; 2: 460, 464, 469; 4: 1163, 1210; 6: 1888, 1893-4
- Instinct and instinctual drives**, 1: 110, 144, 145; 3: 859-71; 4: 1155, 1258, 1362, 1405; 6: 1926
- Institute for Child Guidance (N.Y.C.)**, 3: 1095
- Institute for Handwriting Research (Budapest)**, 2: 686
- Institute of Mathematical Statistics**, 4: 1426
- Institute of Pastoral Care**, 4: 1452
- Institutional care and institutionalization**, 1: 4, 8; 4: 1171; 6: 1997
- Instrumental behavior (learning)**, 5: 1621
- Insulin and insulin shock therapy**, 2: 471; 3: 745, 768, 772; 4: 1173, 1343, 1375, 1419, 1483; 5: 1569, 1574, 1595, 1722; 6: 2053, 2077
- Insurance**. *See* Health insurance
- Insurance money (widow's)**, 6: 2018-19
- Integration**, 3: 1069-70, 1072, 1073, 1074, 1083; 4: 1155, 1207, 1473
- Intellectualization**, 6: 1919, 1978
- Intelligence and intelligence testing**, 1: 265; 2: 397, 661, 730-31; 3: 852-3, 872-92, 932, 942, 944, 1000, 1079; 4: 1181, 1185, 1326, 1338; 5: 1605, 1629
See also Intelligence quotient
- Intelligence quotient**. *See* I.Q. and I.Q. tests
- Interaction, principle of (intelligence)**, 3: 873
- Interdependence**, 2: 451, 454, 590
- Internalization**, 2: 598, 718; 4: 1245, 1246
- International College of Surgeons**, 4: 1331
- International Committee for Mental Hygiene**, 3: 1099; 6: 2060
- International Congress on Mental Health**, 6: 2061
- International Congress on Mental Hygiene**, 3: 1099; 6: 2060
- International Council of Group Psychotherapy**, 6: 1998
- International Directory of Psychologists**, 5: 1625
- International image**, 5: 1550, 1580
- International Labor Organization (U.N.)**, 6: 2062
- International Opium Commission (1909)**, 4: 1277
- International Psychoanalytic Association**, 2: 640; 5: 1594
- International Statistical Classification of Diseases**, 3: 1032, 1039, 1040, 1041
- International Statistical Institute of London**, 3: 1032
- International tensions**, 6: 2059-61
- Interpersonal relations**, 2: 590; 3: 855, 949, 1071, 1074, 1082; 4: 1213, 1219, 1340; 5: 1561, 1574, 1596, 1734; 6: 1875, 1921, 1926
- Interpretation**, 3: 798, 1087; 5: 1515, 1598; 6: 1990, 2005
- Interpretation of Dreams, The** (S. Freud), 2: 509; 5: 1591
- Interprofessional activity**, 6: 2061
- Interracial Housing** (Deutsch and Collins), 5: 1555
- Interstitial hormone**. *See* Luteinizing hormone
- Interview technique and therapy**, 2: 620, 711-12; 6: 1945
- Intragroup problems**, 4: 1219
- Introjection**, 1: 279; 4: 1155, 1159, 1163, 1164
- Introspection**, 2: 461, 467, 544, 563; 3: 857
- Introverts**, 4: 1340, 1468
- Invalidism, psychological**, 5: 1717
- Invasion from Mars, The** (radio program), 3: 996

- Involutional melancholia and involutional psychosis, 2: 462, 464, 466, 470, 472, 563, 729; 3: 772, 1020, 1056, 1059, 1063; 4: 1210, 1211
 Iproniazid, 1: 228
 I.Q. and I.Q. tests, 1: 154, 297, 300-301; 2: 662, 667-9, 674, 676, 677, 693, 730, 888, 934; 4: 1182, 1198-9; 5: 1612
 Ireland, 1: 30; 2: 696; 3: 874, 1064-6; 5: 1536; 6: 1902, 1983, 1984
 "Irresistible impulse" rule, 2: 513; 3: 910-11
 Islamic Empire, 6: 2007
 Islets of Langerhans, 3: 767, 768, 769
 Isolation, 1: 293, 322, 332; 2: 715; 3: 1044, 1083; 4: 1160-61, 1164, 1334, 1342; 5: 1507, 1784; 6: 1967, 2005, 2008, 2077
 Israel, 2: 601, 603, 699; 5: 1561; 6: 2058
 Italy, 1: 183; 2: 664; 3: 1065; 6: 1902, 1983
It Takes All Kinds (film), 5: 1845

 "Jack the Ripper," 5: 1860
 Japan, 1: 11, 133; 2: 486, 534, 565, 682, 683; 3: 887; 4: 1277; 5: 1536, 1538, 1625, 1666; 6: 1902, 1983, 1984, 2009
 Jaundice, 1: 26, 108; 5: 1659
 Jealousy, 1: 304, 349; 2: 549, 601; 3: 758, 966; 4: 1407, 1410, 1416-18, 1446; 5: 1548; 6: 2059
Jealousy (film), 5: 1845
 Jerry Price Seizure Clinic (Los Angeles), 2: 580
 Jewish Association of Hospital Chaplains, 4: 1453
 Jews and Judaism, 3: 738, 739, 874, 1063-4; 4: 1251, 1450, 1451; 5: 1547, 1748; 6: 1973
 See also Judeo-Christianity
 Job security, 6: 2039, 2042
 Johns Hopkins University, 1: 18, 314; 2: 447; 3: 745, 814, 1091; 5: 1786; 6: 1997
 Joint Commission on Accreditation of Hospitals, 4: 1123, 1134, 1150
 Joint Commission on Mental Illness and Health, 1: 126, 130, 132, 134, 138, 261, 262, 274, 317; 2: 563, 608; 3: 1100, 1101; 4: 1117, 1119, 1120, 1121, 1125, 1141, 1453; 5: 1575, 1624, 1627, 1766
 Joint Information Service (N.A.M.H. and A.P.A.), 4: 1291
Joint Statement on the Use of Hypnosis in Athletics (A.M.A.), 3: 805
 Jokes. *See* Humor
Journal of Abnormal and Social Psychology, 3: 973
Journal of Parapsychology, 4: 1427
Journal of Pediatrics, 1: 107
Journal of Social Issues, 5: 1507
 Judeo-Christianity, 4: 1244, 1247; 5: 1533, 1748, 1755-8
 Judge Baker Foundation and Guidance Clinic, 3: 1095; 5: 1805
 Juke family, 4: 1189
 Juvenile addiction, 4: 1279
 Juvenile courts, 3: 902, 903, 904, 905; 6: 1872
 Juvenile delinquency, 1: 66; 2: 477, 494; 3: 893-907, 1095; 4: 1106, 1200, 1294, 1295, 1484; 5: 1514, 1708; 6: 1867, 1945, 1949, 1982, 1996, 2009, 2057
 Juvenile Delinquency and Youth Offenses Act (1961), 3: 907
 Juvenile Delinquency Services Division (H.E.W.), 3: 907
 Juvenile diabetes, 1: 175, 176
 Juvenile Psychopathic Institute (Chicago), 3: 1095

 Kaiser Foundation Health Plans, 4: 1150
 Kallikak family, 4: 1189
 "Keeping up with the Joneses," 6: 1938
 Kennedy Administration, 4: 1153
 Kernicterus, 4: 1327
 Kindergarten, 5: 1808-11
 Kinesics, 1: 327, 328
 King-Anderson bill (87th Cong.), 4: 1153
 Kings County Hospital (N.Y.C.), 1: 26
 Kinsey reports. *See* in Name Index
 Kirkbride Plan (hospital architecture), 4: 1139
 Kissing, 5: 1682, 1697
 Kleptomania, 3: 899; 5: 1860
 Koran, 4: 1187
 Korea and Korean War, 1: 253, 254, 255, 256, 257; 2: 435; 4: 1225, 1229; 6: 2008
 "Koro," 6: 1901
 Kraepelin scale, 2: 686
 Kuder test, 5: 1609
 Kuhlmann-Anderson Intelligence Test, 2: 668
 Ku Klux Klan, 6: 2010

 Labor (childbirth), 1: 92-3, 351-2; 3: 1026
 Lactation, 3: 1029; 4: 1379
La Dolce Vita (film), 1: 281
 Langley Porter Clinic (San Francisco), 2: 439
 Language and language disabilities, 1: 208, 324-6; 2: 598, 681, 683, 697, 699, 700, 702; 4: 1181, 1478; 5: 1619, 1665, 1686
 Lasker Press Award, 2: 477
 "Late bloomers," 1: 66
 Late marriage, 5: 1533, 1536
 Latency period, 1: 291; 5: 1589

- Latin America**, 6: 2051
See also under name of country
Laughter, 3: 786-7, 789-90; 4: 1196
Laura Spelman Rockefeller Memorial, 2: 417
Law and psychiatry, 2: 409-10, 477, 579; 3: 908-29, 1096, 1097, 1100; 4: 1348; 5: 1578, 1630
 and psychopaths, 5: 1852-4, 1858-66
Law and the Modern Mind (J. D. Frank), 5: 1526
"Law of effect" (Thorndike), 4: 1261
Lay analysts, 5: 1600, 1730
Leadership, 2: 297; 4: 1228; 6: 2030, 2037-8
Learning and reading, 1: 158, 288-93, 320; 3: 859-63, 867, 869, 871, 872, 930-49, 998, 1001-1002, 1080; 4: 1198-9, 1232, 1245, 1246, 1259, 1316, 1349, 1458, 1460; 5: 1491, 1516, 1517, 1520, 1577, 1619, 1621, 1628, 1673, 1805-7; 6: 1992
Leg amputation, 4: 1391
Leisure, 4: 1206; 5: 1512
Leptosomic temperament, 2: 363
Lesbians, 3: 747, 757, 761, 762; 5: 1850
 "Lesbians" under Lesbians
Leukorrhea, 2: 654
L.H. *See* Luteinizing hormone
Libido, 1: 291; 2: 653; 3: 768, 771, 953; 5: 1589, 1591
Library of Congress, 4: 1331
Licensed Beverage Industries, Inc., 6: 2080
Life (publication), 5: 1630
Life expectancy, 1: 3, 61; 2: 536; 3: 1051; 4: 1204
Life instinct, 2: 446; 3: 865
Life Insurance and Medicine (Ungerleider and Gubner), 1: 132
Life space, 4: 1470, 1478
Literature, 4: 1469; 5: 1575, 1579-80
 "Little Hans," 5: 1488-90
Lobotomy, 1: 23; 3: 745; 4: 1343, 1373, 1400-1401; 5: 1725; 6: 2053
Loneliness, 1: 40, 80, 154; 2: 487-8, 526, 627; 3: 994; 4: 1196, 1409; 6: 2046
Long-Term Illness (Leake), 5: 1195
Los Angeles State College (Calif.), 2: 436, 448
Lourdes (France), 4: 1433; 5: 1728
Love and love deprivation, 1: 67, 287; 2: 382-3, 535, 549, 629, 654; 3: 841, 843, 866, 950-57, 968, 969, 973, 977, 994, 1013, 1019, 1075, 1078; 4: 1245, 1341, 1474; 5: 1561; 6: 1869, 2026, 2027, 2029, 2054, 2056, 2064, 2065, 2070
 and sex, 2: 382, 551
 See also Romantic love
Love and Marriage (Magoun), 3: 968
Love object, loss of, 3: 960, 1035, 1046
L.S.D. *See* Lysergic acid diethylamide
L.T.H. *See* Prolactin
Luddite rioters, 6: 1910
Lumbar puncture, 4: 1328, 1329
Lunacy, 3: 908
Luteinizing and luteotrophic hormones, 3: 768
Lycanthropy, 4: 1336
Lynching, 5: 1529, 1546
Lysergic acid diethylamide, 1: 232, 233; 2: 502, 508; 5: 1656, 1657, 1673, 1796, 1840; 6: 2005
M.A. *See* Mental age
McGill University (Canada), 5: 1837
M'Naghten Rule, 1: 144; 2: 410, 411, 513; 3: 909-10, 911; 4: 1334
Macrocephaly, 4: 1192
Magic, 2: 435, 627; 3: 737, 803, 824; 4: 1434, 5: 1491, 1573
Malaria, 1: 243; 5: 1532; 6: 1901, 1908
Male characteristics, 3: 765, 771
Male climacteric and menopause, 1: 138-9; 6: 2031
Male hormones, 1: 38; 3: 765
Male reproductive system, 1: 336
Male role, 1: 116, 118-19, 128, 295, 348; 2: 495; 3: 747; 4: 1380; 5: 1694; 6: 1867, 1869, 2073
Malingerer, 1: 236; 3: 818; 5: 1498
Malleus Maleficarum, 4: 1337
Malnutrition, 4: 1181, 1363-4, 1370-71; 6: 1962
Man and Wife: A Source Book on Family Attitudes, Sex Behavior and Marriage Counseling (Mudd and Krich, eds.), 3: 968
Manhattan State Hospital (N.Y.C.), 4: 1105; 6: 1944
Mania, 3: 958; 4: 1173, 1315, 1336
Manic-depressive psychosis, 2: 363, 461, 462, 464, 471, 555, 556, 562, 726, 729; 3: 958-64, 995, 1056, 1057, 1059, 1060, 1063, 1064; 4: 1338, 1374, 1404, 1408, 1410, 1411-12, 1468, 1479, 1481, 1483; 5: 1523, 1665-67, 1669
Man's Capacity to Reproduce (Eaton and Mayer), 5: 1540
Marfan's syndrome, 2: 360
Marihuana, 3: 1082; 4: 1276, 1278, 1279, 1281
"Marital Disagreement in Working Wife Marriages as a Function of Husband's Attitude Toward Wife's Employment" (Gianopoulos and Mitchell), 3: 970
Marriage (Blood), 3: 976

- Marriage and Family Living* (publication), 3: 970
- Marriage Council of Philadelphia, 3: 968
- Marriage Counseling, A Casebook* (Amer. Assoc. of Marriage Counselors), 3: 986, 989
- Marriage for Moderns* (Bowman, ed.), 3: 969
- Marriage Manual* (Stone and Stone), 3: 968
- Marriage, marital adjustment, and marital problems, 1: 111-13, 137, 348, 349; 2: 382-4, 386, 390-91, 395, 483, 484, 485, 488, 650, 651, 656, 657; 3: 755, 823, 954, 963, 965-78, 983, 984, 1019; 4: 1207-8, 1213, 1342, 1381, 1450; 5: 1512, 1576, 1612; 6: 1879, 2023, 2032, 2054, 2065-7, 2069, 2071, 2074
- and children, 3: 971-2; 4: 1438
- See also Parenthood
- and sex relations, 6: 1867-85
- communication in, 5: 656, 690, 708; 6: 1866, 1879
- counseling, 1: 198; 2: 389, 394, 496; 3: 744, 968, 978, 979-89; 5: 1562, 1568, 1615-1616; 6: 1884
- education, 5: 1844
- See also Sex education
- infidelity, 1: 113, 137, 138, 176; 2: 485; 3: 981; 4: 1207; 6: 1880-82, 1966
- See also Mate choice; Premarital counseling
- Marriage Today* (film), 5: 1845
- Masculinity, 1: 128, 133, 134, 136, 191; 4: 1430
- Masochism, 4: 1339, 1405; 5: 1697, 1849; 6: 1882
- Massachusetts General Hospital, 2: 447; 3: 771; 4: 1450
- Massachusetts Institute of Technology, 3: 1081; 6: 2033
- Massachusetts Mental Health Center (Boston), 1: 124
- Mass hysteria, 3: 824, 990-97; 5: 1529, 1546
- Mass media, 3: 996, 1098; 5: 1585; 6: 1905, 1927, 1997, 2076
- Masturbation and masturbation guilt, 1: 52, 62, 140; 2: 392, 506, 647, 653; 3: 750, 763, 835, 836, 841, 845, 1014; 5: 1517, 1690, 1693-4, 1702, 1847, 1848, 1850; 6: 1877, 1966
- "Matchbox of the East," 6: 1868
- Mate choice, 3: 973; 4: 1308; 5: 1562, 1845; 6: 1868, 1884
- Maternal and child welfare, 4: 1130
- Maternal behavior, 1: 295-6; 3: 752, 859, 861, 864; 4: 1444
- See also Mother-child relation
- Maternal Care and Mental Health* (Bowlby), 6: 1911
- Maternal deprivation, 1: 36, 75; 2: 626, 627; 4: 1441; 5: 1764; 6: 2065
- Maternal overprotection, 1: 113, 306; 2: 454, 538, 598; 4: 1368, 1380, 1441, 1443
- Maternity shelter, 1: 81
- Maturation and maturity, 1: 37, 51-2, 109, 110, 116, 135, 300; 2: 387, 451, 452, 533, 545, 629; 3: 953, 963, 969, 977, 1037; 4: 1205, 1408, 1460; 6: 2063, 2070
- Maze experiment. See Animal experiments
- Meaning and meaninglessness, 1: 321; 4: 1254; 5: 1471
- Meaning of Engagement, The* (film), 5: 1845
- Measles, 1: 243; 4: 1183, 1192
- Mecholyl, 2: 554
- Medical Clinics of North America*, 5: 1712 n.
- Medical examinations, periodic, 1: 135
- Medical profession, 3: 1067, 1096, 1097; 4: 1428
- Medical-psychotherapeutic approach, 5: 1721
- Medicare law, 4: 1220
- Medicine at Work* (publication), 3: 815
- Medicine men, 4: 1391, 1425
- Medium (spiritualistic), 4: 1421, 1424, 1427, 1432, 1433
- Melancholia, 2: 465, 3: 738; 4: 1213, 1401; 6: 2014-15
- See also Involutional psychosis
- Memory and memory impairment, 1: 158, 159, 238, 245, 343; 2: 635; 3: 819, 821, 830, 878, 880, 931; 3: 998-1010; 4: 1160, 1208, 1210, 1458, 1460, 1483; 5: 1628, 1663, 1831
- Menarche, 1: 337; 3: 1011-15, 1016, 1024
- Meningitis, 1: 243, 244; 2: 575, 581
- Menninger Foundation and Menninger Foundation Hospital, 1: 124, 111, 142
- Menopause, 1: 138, 337, 338; 2: 525, 562, 563, 644, 646, 647; 3: 772, 773, 1016-23, 1056; 4: 1207, 1342, 1415
- Menorrhagia, 3: 1030
- Menstrual cycle. See Menstruation and sexual cycle
- Menstruation and sexual cycle, 1: 39, 42, 43, 338; 2: 463; 3: 765, 767, 768, 1024-31; 4: 1391; 5: 1536, 1539, 1678
- See also Menarche
- Mental age, 2: 883, 884
- Mental alienist, 5: 1581
- Mental defects and deficiencies, 2: 726, 730; 3: 886, 890, 900, 911, 913, 1032, 1036, 1041, 1043, 1048, 1079; 4: 1104, 1109, 1226, 1337; 6: 2053-4
- See also Mental retardation
- Mental disease, incidence and prevalence, 2: 560-62

- Mental disorders**, 1: 130, 159, 166-7, 169-70; 2: 558; 3: 1051-66; 4: 1326-7; 5: 1556-1566
 classification, 3: 1032-50; 4: 1307, 1338-9
 history of treatment, 3: 737-46
 prevention, 5: 1556-66
- Mental health and mental health movement**, 1: 1-8, 125; 2: 356, 563; 3: 1067-79, 1091-1102; 4: 1484; 6: 1907, 1931
 careers, 1: 258-75
 community services, 4: 1103-21; 5: 1746
 educational campaigns, 4: 1119; 5: 1834, 1836; 6: 2055-6
 in college, 3: 1080-90
 See also Students and mental health
 optimum, 1: 1-8; 2: 423-4; 3: 957
 school services, 5: 1822-8
 world-wide, 6: 2049-62
 See also Mental Hygiene
- Mental Health Association**, 3: 775
- Mental Health Bell Ringers' March**, 4: 1287
- Mental Health in College** (Fry and Rostov), 3: 1081
- Mental Health in College and University** (Farnsworth), 3: 1084
- Mental Health in International Perspective** (World Fed. for M.H.), 2: 423
- Mental Health in the U.S.: A Fifty-Year History** (Ridenour), 3: 1101
- Mental Health Is 1, 2, 3** (N.A.M.H.), 4: 1290
- Mental Health Manpower Trends** (Albee), 1: 273
- Mental Health Materials Center**, 6: 2079
- Mental health professionals**, 1: 258-60; 2: 369, 529-30; 3: 1100; 4: 1103-21, 1107, 1118, 1292; 5: 1568
 See also under name of specialty
- "Mental Health Programs in American Colleges and Universities"** (Gundle and Kraft), 3: 1083-4
- Mental Health Project Grants** (NIMH), 4: 1296, 1300
- Mental Health Study Act** (1955), 3: 1100, 1102
- Mental Health Study Center** (NIMH), 4: 1294-5, 1296
- Mental Hospital Chaplains Association**, 4: 1453
- Mental hospitals**, 1: 5, 124, 167, 175-6; 2: 478-9, 605; 3: 1099, 1100; 4: 1103, 1104, 1121, 1122-45, 1168; 5: 1595; 6: 1929, 2052, 2057
 private, 4: 1133-5, 1137, 1140, 1143
- Mental Hospital Survey Committee**, 3: 1093
- Mental Hygiene** (publication), 3: 744, 1089, 1092, 1094; 4: 1290
- Mental Hygiene Consultation Services**, 4: 1218, 1220, 1223, 1229
- Mental Hygiene in Teaching** (Redl and Wattenberg), 5: 1812
- Mental Hygiene Society** (Conn.), 6: 2060
- Mental illness**, 1: 6-7, 69, 227-34, 260; 2: 402-3, 423; 3: 776, 778, 1037, 1055-6, 1067; 4: 1109
 and health insurance, 4: 1146-53
 and social status. *See* Socioeconomic factors
- "Mentally Disabled and the Law, The"** (Amer. Bar Foundation), 5: 1859, 1862
- Mentally Ill in America, The** (A. Deutsch), 2: 476; 3: 1101
- Mental mechanisms**, 1: 110, 256; 2: 621, 723; 3: 752, 830, 854, 855, 1040, 1045; 4: 1154-65, 1216, 1263, 1339, 1367, 1479; 5: 1488, 1496, 1499, 1594; 6: 1919, 1977, 1978, 2000
- Mental patients**, 4: 1166-79; 6: 1923-4
 chronic, 5: 1743-4
- Mental retardation**, 1: 228, 299, 313; 2: 404; 3: 853, 877, 879, 890-91, 895; 4: 1112, 1116, 1129, 1130, 1144, 1180-1203, 1295, 1327, 1365, 1366; 5: 1521-2, 1762; 6: 1955
 See also Children, retarded
- Mental tests**, 3: 1092; 5: 1605
 See also Psychological tests
- Men Under Stress** (Grinker and Spiegel), 1: 131
- Meperidine**, 4: 1279
- Meprobamate**, 5: 1635
- Mescaline**, 1: 233, 2: 502, 508; 3: 1082; 5: 1796; 6: 2005
- Mesomorphy**, 2: 357-8, 361; 3: 897; 4: 1468, 1469
- Metabolic disorders and metabolism**, 2: 581; 4: 1327, 1333, 1354, 1365, 1367; 5: 1762
 See also under specific type of metabolism
- Metapsychology**, 4: 1340; 5: 1592
 See also Psi
- Methadone**, 4: 1276, 1278, 1279
- Metrazol**, 4: 1173, 1315; 5: 1722
- Mexico**, 2: 372, 434; 4: 1278; 6: 1983
- Meyer Memorial Award**. *See* Adolph Meyer Memorial Award
- Michigan State University**, 2: 670
- Microcephaly**, 4: 1193
- Microsleeps**, 6: 1887, 1888
- Middle age**, 1: 109, 112, 120, 128, 129, 138, 139, 163; 2: 488, 562, 563; 3: 888, 1022, 1056; 4: 1204-12, 1342, 1374, 1460-61; 5: 1709; 6: 2031, 2063, 2075
- Middle Ages**, 5: 1729
- Middle-class standards**, 1: 134; 4: 1442
- Middle East**, 6: 2007
- Migraine**, 2: 582, 721, 723; 4: 1392, 1403

Milieu therapy, 2: 374; 4: 1122, 1194, 1230, 1482
See also Therapeutic community
Military considerations and military psychiatry, 1: 49, 263; 4: 1213-30, 1337; 5: 1629; 6: 1871
See also War
Mill Hill Hospital (London), 6: 1996
Miltown, 5: 1655
Mind, 4: 1231-4, 1312, 1355; 5: 1618, 1619
 -body relation, 3: 1036-7; 4: 1232, 1233; 5: 1711, 1841
Mind that Found Itself, A (Beers), 3: 1091, 1101; 4: 1286
Minerals, 4: 1357
Minnesota Multiphasic Personality Inventory, 2: 468; 4: 1477; 5: 1609
Minority groups, 2: 416; 3: 894
See also under name of group
"Minutemen," 1: 257
"Mirror, the" (psychodrama), 2: 710
Mirror imaging and writing, 2: 701; 4: 1268
Miscarriage, 1: 9, 351
Misperceiving, 4: 1461, 1463, 1464, 1466
Mixed marriage, 3: 970-71, 981
Mobility, 2: 536, 564-5, 604; 6: 1911, 1917, 1935, 1936, 1982, 2068
 and mental health; 4: 1235-43
Mob psychology, 3: 990-91, 993; 5: 1529
"Model sentencing acts," 2: 413
Modern Introduction to the Family (Bell and Vogel), 3: 968
Modesty, 5: 1691
Molly Grows Up (film), 5: 1845
Money problems, 1: 111; 2: 390-91, 967, 971, 972, 976; 6: 2069
Mongolism and mongoloids, 4: 1183, 1193, 1196, 1197, 1200, 1269, 1327; 5: 1762
Monoamine oxidase inhibitors, 5: 1661
Monogamy, 2: 597, 601; 3: 966, 981
Monomania, 3: 914
Mood swings, 1: 342, 348; 2: 464; 3: 1030; 4: 1178, 1210
Morals and mental health, 4: 1244-55; 5: 1752-4; 6: 2071
"Morals, Medicine and the Law" (symposium), 6: 1974
Moral values. See Values
Moreno Institute, 6: 1998
Mormon Church, 1: 11
Moron, 3: 890
Morphadite, 5: 1850
Morphine, 4: 1276, 1279, 1280, 1400
Mother-child relation, 1: 50, 306, 346-8; 2: 452-3, 537, 542, 546, 598, 604, 607, 627, 651; 3: 950; 4: 1237, 1380, 1439, 1476; 5: 1560, 1589, 1740; 6: 1916, 2019

Mother-child relation (Cont.)
See also Childhood experiences; Family; Love
Mother substitutes, 1: 302
Motivation, 2: 415; 3: 805, 930, 931, 934, 935, 936, 938, 939, 948; 4: 1164, 1213, 1237-8, 1256-66, 1461, 1470; 5: 1512, 1517; 6: 1620, 1948, 1976, 1993, 2030, 2033, 2039
Motivation and Emotion (Young), 4: 1266
Motivation to Work, The (Herzberg, Mausner, and Snyderman), 6: 2029
Mt. Sinai Hospital (N.Y.C.), 1: 18
Mourning, 1: 68, 78; 2: 461, 703, 705; 6: 2014, 2017, 2023, 2025
See also Grief
"Mourning and Melancholia" (S. Freud), 5: 1670
Müllerian ducts, 5: 1680
Multiple births, 4: 1267-75
Multiple personality, 3: 821; 4: 1158, 1164; 6: 1892, 2001
Multiple sclerosis, 4: 1327; 5: 1495
Mumps, 1: 243
Murder, 2: 403, 405, 406; 3: 995, 1069, 1083; 5: 1578
Murray Thematic Apperception Test, 2: 418
Muscular dystrophy, 1: 249
Music therapy, 5: 1515
Muslim medicine, 3: 738; 4: 1187
Myelogram, 4: 1328
My Name Is Legion (Leighton), 6: 1911
Mysoline, 2: 570
Mysticism, 3: 738; 4: 1342
Mythology and myths, 2: 635, 649; 3: 373, 1002; 6: 2005
Myxedema, 3: 769, 772

N.A.M.H. See National Association for Mental Health
N.A.M.H. Research Foundation, 4: 1291
Nancy Bayley chart, 2: 359
N.A.R.C. See National Association for Retarded Children
Narcissism, 1: 281; 2: 536; 4: 1337, 1410; 5: 1878, 1967, 2064
Narcoanalysis, 6: 2005
Narcolepsy, 2: 582; 6: 1893
Narcosynthesis, 5: 1839
Narcotic addiction and narcotics, 1: 344; 4: 1123, 1131, 1276-85, 1399, 1403-4; 6: 1894
See also Addiction; Drug addiction
National Advisory Council (NIMH), 4: 1107, 1298
National Association for Gifted Children, 2: 675

- National Association for Mental Health, 1: 274; 2: 479; 3: 1099; 4: 1214, 1286-91; 5: 1575, 1766; 6: 2076, 2079
- National Association of Private Psychiatric Hospitals, 4: 1134
- National Association for Retarded Children, 4: 1181, 1190, 1203
- National Association of Social Workers, 1: 274; 3: 1094; 6: 1947, 2080
- National Catholic Welfare Conference, 6: 2079
- National Committee Against Mental Illness, 1: 121; 5: 1575
- National Committee for Mental Hygiene, 2: 476; 3: 1092, 1093, 1094, 1095, 1096, 1099, 1101; 4: 1106, 1107, 1214, 1286, 1291; 5: 1575; 6: 2060
- National Commission on Social Work Practice, 6: 1951
- National Conference of Charities and Corrections, 6: 1943
- National Conference of Commissioners on Uniform State Laws, 1: 28
- National Conference on Social Welfare, 6: 1913
- National Congress of Parents and Teachers, 5: 1808
- National Council on Alcoholism, 6: 2080
- National Council of Churches, 6: 2080
- National Council on Crime and Delinquency, 2: 379, 413; 3: 893
- National Council on Family Relations, 2: 497
- National Defense Education Act, 2: 675; 5: 1824
- "National Employ the Handicapped Week," 5: 1507
- National Epilepsy League, 2: 579; 6: 2079
- National Federation of Settlements, 1: 275
- National Health Service (British), 3: 788
- National Institute of Mental Health, 1: 122, 240, 261, 274, 319; 2: 479; 3: 781, 907, 1053, 1098; 4: 1127, 1202, 1292-1305; 5: 1746, 1761, 1766, 1767; 6: 2079
- National Institute of Neurological Diseases and Blindness, 4: 1182, 1183, 1184, 1202, 1324
- National Institutes of Health, 4: 1303, 1442; 5: 1576, 1633
- National Jewish Welfare Board, 6: 2079
- National League for Nursing, 1: 274
- National Mental Health Act (1946), 3: 1098; 4: 1107, 1288, 1292-3, 1301; 5: 1766
- National Mental Health Foundation, 3: 1098, 1099; 4: 1286, 1291
- National Organization for Mentally Ill Children, 4: 1291; 6: 2079
- National Rehabilitation Association, 6: 2079
- National Research Council, 4: 1363
- National Science Foundation, 4: 1305
- National Scientific Register, 5: 1625
- National Social Welfare Assembly, 6: 1946
- Natural childbirth, 1: 353-4; 4: 1396, 1398
- Naturalistic view, 5: 1728-9
- Nature of Prejudice, The* (Allport), 5: 1546
- Nazism, 4: 1186; 5: 1524, 1668; 6: 2010
- Necking, 1: 55-6, 162; 2: 382, 385, 393; 5: 1707
- Necrophilia, 5: 1849
- Negroes, 2: 416, 603, 672; 3: 874, 1062-3; 4: 1185, 1278; 5: 1543-4, 1546, 1549, 1550, 1551, 1553, 1675
- Nembutal, 2: 501
- Neo-Freudians, 4: 1470
- Nervous breakdown, 1: 127, 132; 4: 1306-11; 5: 1512
- Nervous exhaustion, 6: 1966
See also Exhaustion syndrome
- Nervousness, 4: 1326, 1329
- Nervous system, 1: 243-4; 3: 999; 4: 1313, 1314, 1317, 1318, 1325, 1366; 5: 1573; 6: 2003, 2006
and behavior, 4: 1213-23
See also Autonomic nervous system; Peripheral nervous system; Vegetative nervous system
- Netherlands, 2: 609, 688, 699; 4: 1112, 1241, 1277; 5: 1671; 6: 1983
- Neurasthenia, 3: 741; 4: 1309
- Neurodermatitis, 5: 1713
- Neurohypophysis, 3: 768
- Neurological disorders and neurology, 1: 259, 264; 3: 740; 4: 1104, 1324-32, 1365; 5: 1573
- Neurological Institute (Montreal, Can.), 2: 570
- Neurons, 4: 1314, 1317-22, 1325
- Neuropathology, 4: 1330
- Neuropharmacology, 4: 1296
- Neurophysiology, 2: 686; 3: 746; 4: 1314, 1323; 5: 1760, 1762; 6: 2006
- Neuropsychiatric Consultants Division (Army Surg. Gen.), 3: 1094
- Neuroses and neurotic problems: 1: 126, 135, 323; 2: 461-3, 465, 468, 471, 489, 490, 556, 565, 625-8, 630-31, 637, 646-7, 654-5, 672, 705, 708, 726-7; 3: 762, 831, 834, 838, 912, 919, 925, 1005, 1013, 1017, 1021, 1027, 1032, 1038, 1041, 1043, 1046; 4: 1114, 1278, 1295, 1333-1345, 1346-53, 1376, 1402; 5: 1488, 1506, 1560, 1575, 1580, 1591, 1599, 1671-2, 1730, 1849; 6: 1952, 1977, 1978, 2050
See also Psychoneuroses

- Neurosurgery, 2: 570; 3: 868, 998; 4: 1330, 1331
- Neurosurgical Society of America, 4: 1331
- Neurotics Anonymous, 3: 743
- Neurotogenicity, 4: 1349, 1350, 1351, 1352
- Newborn, 1: 289-90; 4: 1327; 5: 1678-9
- See also* under Infants
- New England, 6: 1908
- New Haven Study, 3: 1052, 1061; 6: 1915-6, 1923
- New School for Social Research (N.Y.C.), 2: 688
- New Trends in the Care and Treatment of the Mentally Ill* (N.A.M.H.), 4: 1290
- New York Academy of Medicine, 4: 1283
- New York Board of Rabbis, 6: 1973
- New York Cancer Society, 2: 442
- New York City Narcotic Clinic, 4: 1279
- New York Hospital (White Plains), 1: 124
- New York Newspaper Guild, 2: 476
- New York School of Philanthropy. *See* Columbia University-New York School of Social Work
- New York State Association for Mental Health, 3: 1091
- New York State Care Act (1890), 4: 1104; 6: 1944
- New York State Charities Aid Association, 4: 1105
- New York State Department of Mental Hygiene, 4: 1106
- New York State Department of Social Welfare, 2: 475
- New York State Medical Society, 4: 1283-4
- New York State Psychiatric Institute, 4: 1106
- New York Times*, 1: 155
- New Zealand, 2: 483; 5: 1571
- Nicaragua, 6: 1983
- Nicotinic acid, 1: 227
- Night hospitals, 3: 777; 4: 1113-4, 1136; 5: 1744
- Night terrors and nightmares, 2: 505, 509, 511, 538, 551; 5: 1692
- NIMH. *See* National Institute of Mental Health
- Nirvana idea, 3: 1075
- Nocturnal emissions, 2: 506, 507; 6: 1878
- Nomenclature of Mental Disorders, 3: 1032, 1093
- See also* Standard Nomenclature
- Nonviolence, 5: 1528
- Noradrenalin, 2: 549
- Norepinephrine, 1: 231; 3: 768
- Northfield Experiment (Birmingham, Engl.), 6: 1996
- Norway, 1: 10, 231; 4: 1236; 6: 1916, 1983
- Nose, 4: 1465
- Nostalgia, 4: 1213
- Novak's Textbook of Gynecology* (Novak and Jones), 3: 1029
- Nuclear family, 3: 968
- Nuclear threat, 1: 48, 215; 2: 448, 645; 5: 1547, 1701; 6: 2010, 2011
- Nudity, household, 5: 1691, 1844
- Nuremberg Diary* (Gilbert), 5: 1524
- Nursemaids, 2: 653
- Nursery schools, 1: 316; 3: 873; 5: 1799-80
- Nurses and nursing profession, 1: 260, 272, 274; 6: 2056
- See also* Practical nursing; Psychiatric nursing; Public health nursing; Visiting Nurse Association
- Nursing. *See* Lactation
- Nursing homes, 1: 161, 175-6; 5: 1834
- Nutrition, 2: 364; 3: 1011, 1014; 4: 1186, 1191; 6: 1908, 1968
- and mental health, 4: 1351-71
- Oak Knoll Naval Hospital (Calif.), 6: 1996
- Obesity, 1: 52, 53, 324; 2: 365; 3: 773, 812; 4: 1365, 1367, 1369, 1372-85
- Obsessive-compulsive character and neurosis, 1: 281-2, 324; 2: 545, 635, 716, 717, 731; 3: 825, 1038, 1045, 1049; 4: 1158, 1160, 1163, 1253, 1263, 1342, 1343, 1350
- Obstinacy, 1: 147, 294; 4: 1409
- Occult, The, 4: 1421-36
- Occupational therapy, 1: 258, 262, 272-3; 4: 1168, 1219; 5: 1514, 1772; 6: 2043, 2053, 2077
- Oedipus complex, 1: 281, 282, 291, 295; 2: 601, 636; 3: 824; 4: 1248; 5: 1488, 1589, 1687-8
- Office of Vocational Rehabilitation. *See* U.S. Office of Vocational Rehabilitation
- Old age. *See* Aged and aging
- Oligomenorrhea, 3: 1026, 1030
- One Hundred Years of American Psychiatry* (Lowrey, ed.), 3: 1101
- Only child, 5: 1807
- "Open door" policy, 4: 1170; 5: 1658; 6: 2052, 2053
- Ophthalmology, 4: 1330
- Opiates, 4: 1277, 1278
- See also* under Narcotics
- Opinions and Personality* (Smith, Bruner, and White), 5: 1552
- Optimum mental health, 1: 1-8; 2: 423-4; 3: 957
- Oral phase/stage, 1: 281, 291; 2: 499, 4: 1339; 5: 1589, 1682
- Orderliness, 2: 291, 292; 4: 1164, 1254, 1409; 6: 2064
- Ordinal position. *See* Birth order

- Organic brain disorders, 3: 1033, 1064; 4: 1464; 5: 1829
- Organicist view, 2: 639
- Organic school, 5: 1569, 1571, 1665-6, 1786
- Orgasm, 2: 507, 643, 644, 651, 656; 3: 748, 758, 972, 1071; 6: 1877
- Orgone theory, 2: 641
- Orient, 4: 1187
- See also* under name of country
- Orthopsychiatry 1923-1948: *Retrospect and Prospect* (Lowrey, ed.), 3: 1101
- Osteopathy, 5: 1730
- Otis Quick-Scoring Mental Ability Test, 3: 668
- Otolaryngology, 4: 1330
- Our Age of Unreason* (Alexander), 1: 127
- Our Rejected Children* (A. Deutsch), 2: 477
- Out-group, 5: 1552
- Outline of Psychoanalysis, An* (S. Freud), 2: 517
- Outpatient clinics and outpatients, 4: 1110, 1111-12, 1138, 1219, 1221; 5: 1740; 6: 1994, 2079
- therapy, 5: 1745
- See also* Clinics
- Overcompensation. *See* Compensation
- Overdependence. *See* Dependence
- Overdeterminism. *See* Psychic determinism
- Overdiscipline. *See* Discipline
- Overeating, 4: 1158, 1375, 1379; 6: 2071
- Overindulgence, 1: 92, 291; 3: 960, 964; 4: 1441
- Overprotection, 5: 1807
- Overseas employment, 6: 2036
- Overweight. *See* Obesity
- Ovulation, 2: 647; 3: 765, 767, 768, 1017, 1019, 1020
- "Oxford School, the" (language), 1: 331
- Oxygen and oxygen deprivation, 4: 1183, 1192, 1315, 1365
- Oxytocic hormone, 3: 768
- Pain, 3: 1006; 4: 1386-1406, 1134; 5: 1500; 6: 2005, 2016, 2022, 2025
- "Pain blind," 4: 1386, 1392
- Painless childbirth. *See* Natural childbirth
- Pakistan, 4: 1369
- Palsy, 4: 1324
- Pampering, 4: 1408
- See also* Overindulgence
- Pan American Sanitary Bureau (W.H.O.), 6: 2080
- Pancreas, 3: 767, 768; 4: 1375
- Panic, 1: 129; 2: 550, 624, 628, 629, 630, 631; 3: 990, 992, 997, 1081-2; 4: 1333, 1334; 5: 1486, 1564; 6: 1910, 1978
- Pansexuality, 3: 749
- "Papers on Metapsychology" (S. Freud), 5: 1592
- Paralanguage, 1: 326, 328
- Paralysis, 3: 819; 4: 1216, 1312, 1366; 5: 1501
- Paramnesia, 3: 770, 782, 1001, 1043, 1046, 1048
- Paranoia, 3: 770, 782, 1043, 1046, 1048; 4: 1335, 1407-20; 5: 1523, 1552, 1669
- See also* Paranoid delusions
- Paranoid delusions, 2: 363, 422, 461, 464, 564; 4: 1234, 1334, 1338, 1407, 1409, 1412-15, 1418; 5: 1567, 1785, 1832
- Paraphrenia. *See* Paranoia
- Paraplegia, 5: 1507
- Parapsychology, 4: 1421-36
- Parapsychology Foundation (N.Y.C.), 2: 437; 4: 1428
- Parapsychology Laboratory (Duke Univ.), 4: 1426, 1427, 1428
- Parasympathomimetic drug, 2: 554
- Parathyroid, 3: 767, 768
- Parent and parents, -adolescent relations, 1: 50, 54, 56, 57, 58, 61
- authority, 1: 54; 2: 602
- child relations, 1: 40-41, 55, 113, 116, 305; 2: 421, 491, 540, 591-2, 603; 3: 899-900, 1012; 4: 1408-9, 1437, 1440-1443; 5: 1541, 1563, 1571, 1589; 6: 2026
- See also* Father-son relation; Mother-child relation
- counseling, 6: 1958, 1959
- See also* Family counseling
- discord, 1: 67, 146
- expectations, 6: 1917, 1937
- substitutes, 4: 1155, 1160; 5: 1812-13
- teacher relations, 5: 1808, 1815-16
- See also* Parenthood
- Parenthood, 1: 128-9, 297-9, 342; 2: 529, 535; 3: 835, 964, 969, 974; 4: 1437-48; 5: 1317, 2032, 2067-8
- Parents Without Partners, 3: 495; 6: 2019
- Paresis, 1: 243; 4: 1056, 1057, 1059, 1060, 1062, 1064, 1481; 5: 1557
- Parkinson's disease, 4: 1324, 1327
- Parole, 2: 377
- Parkinson's disease, 4: 1324, 1327
- Parole, 2: 377
- Paroxysmal disorders, 2: 569-82
- Parsimony, 1: 291, 292
- Passive-aggressive, 3: 1046
- Passivity, 6: 2073, 2074
- Pastoral counseling and pastoral psychiatry, 1: 203, 259; 2: 706, 718; 3: 745, 987; 4: 1449-57; 5: 1578, 1579, 1585, 1758
- See also* Clergy
- Pathological Institute of N. Y. State Hospitals, 4: 1104
- Patient and patients
- as a whole, 6: 1711

- Patient and patients (*Cont.*)
 -physician relation, 1: 334; 3: 813, 923-4, 979, 980, 984; 5: 1579, 1728; 6: 2052
See also Mental patients
- Pavor nocturnus, 2: 505
See also Night terrors
- Pearl Harbor, 6: 2008
- "Pecking order," 5: 1551
- Pediatrics, 3: 984
- Pedophilia, 5: 1848, 1851
- "Peeping Tom," 5: 1848, 1863
- Peer groups, 1: 54, 61; 4: 1173, 1448
- Pellagra, 1: 227-8; 2: 558; 4: 1173, 1365, 1408; 5: 1557
- Penicillin, 4: 1173
- Penis envy, 2: 646, 649; 5: 1688
- Pennsylvania State University, 2: 670
- People of Cove and Woodlot* (Hughes), 6: 1911
- "Pep-pills," 2: 470
- Peptic ulcers. *See* Ulcers
- Perception, 1: 31, 32; 3: 1070-71, 1076; 4: 1458-66, 1477, 1478, 1480, 1481; 5: 1619, 1792
- Performance tests, 3: 883, 885, 890; 5: 1609
- Peripheral nervous system, 4: 1325
- Permissiveness, 1: 293, 295, 320; 2: 383; 5: 1578; 6: 1979
- Pernicious anemia, 4: 1408
- Persecution ideas. *See* Delusions of persecution; Paranoia; Paranoid delusions
- Persia, 4: 1277
- Personality and culture, 2: 415-26
- Personality development and disturbance, 1: 290-93; 2: 356, 361, 415-26, 679, 680; 3: 826, 827, 912, 914, 973, 1032, 1036, 1041, 1043, 1046, 1077; 4: 1278, 1307, 1309, 1311, 1342, 1444, 1463, 1467-84; 5: 1526, 1619, 1621, 1764-5; 6: 1900, 1916-7, 1921, 1926, 1929, 1947, 2063
- Personality integration. *See* Integration
- Personality testing and tests, 1: 265; 2: 661; 3: 944; 4: 1476-7; 5: 1608-17; 6: 2032
- Personology, 5: 1621
- Perversions, 4: 1404, 1405; 5: 1692
See also Sexual deviations; under name of perversion
- Pessimism, 2: 460-468
- Pest eradication, 5: 1532
- Petit mal, 2: 569, 571-2, 576
- Petting, 2: 382, 385, 392, 393, 648
- Peyote, 1: 233; 4: 1276; 5: 1656; 6: 1905
- Phallic phase/stage, 1: 281; 5: 1589
- Phallic symbols, 2: 510
- Pharmacology and pharmacopoeia, 4: 1296; 6: 1905
- Pharmacotherapy, 3: 745, 1086; 4: 1209, 1420; 6: 2053, 2077
- Phenmetrazine, 4: 1381
- Phenobarbital, 2: 570, 578
- Phenothiazine, 4: 1343, 1419; 5: 1655
- Phenylketonuria, 1: 228, 245; 4: 1191, 1327; 5: 1762
- Philadelphia Department of Health, 1: 165
- Philippines, 4: 1277
- Philosophy, 5: 1579-80, 1620
- Philosophy and Psychoanalysis* (Wittgenstein), 1: 331
- Phipps Psychiatric Institute, 3: 814
- Phobia and phobias, 1: 212-13, 215, 324; 2: 625, 631, 635; 3: 818, 1005, 1045, 1049; 4: 1157, 1164, 1216, 1263, 1333, 1334, 1340, 1341, 1342, 1350, 1404; 5: 1485-1493, 1498, 1594, 1602
- Phoenicians, 2: 682
- Phonogram, 2: 684
- Phrenology, 2: 688; 4: 1312
- P.H.S. *See* U.S. Public Health Service
- Physical attraction, 2: 382, 384; 3: 950
- Physical Disability—A Psychological Approach* (Wright), 5: 1505
- "Physical Disability as a Social Psychological Problem" (Meyerson), 5: 1507
- Physical handicaps, 5: 1501-10
- Physically ill, mental health of, 5: 1491-1500
- Physical sciences, 2: 523, 524; 4: 1428
- Physiochemical disorders, 1: 324
- Physiological psychology and physiology, 2: 685, 696; 3: 955; 4: 1428
- Physiotherapy, 3: 745
- Physique and Character* (Kretschmer), 2: 363
- Pictograms and picture signs, 2: 682, 684
- Picture Interpretation test, 2: 418
- Pineal gland, 3: 769
- "Pinning," 1: 381, 387; 5: 1707
- Pituitary gland and hormone, 1: 38, 39, 183; 3: 768, 769, 1017, 1024, 1025; 6: 1979
- Pius XII, 3: 811
- P.K.U. *See* Phenylketonuria
- Planned parenthood and Planned Parenthood Federation of America, 1: 14, 28; 2: 660; 5: 1538, 1539
- Plastic surgery, 4: 1384
- Platonic relation, 3: 953
- Play and play therapy, 1: 314, 318; 4: 1111; 5: 1511-22, 1602
See also Children's play
- "Pleasure principle," 5: 1590-91
- Plimssoll mark, psychiatric, 6: 1980
- "Pluralistic" theories, 5: 1665
- PM* (newspaper), 2: 476
- Pneumonia, 4: 1183

- Police, 2: 409; 3: 902, 905; 5: 1526-7
 "Policeman at the elbow" test, 3: 911
 Poliomyelitis, 1: 243, 289; 5: 1495
 Political crisis, 5: 1528, 1529-30
Political Life: Why People Get Involved in Politics (Lane), 5: 1530
 Politics and political considerations, 5: 1523-30; 6: 2045-6
 Polk Memorial Award, 2: 477
 Poltergeist, 4: 1421, 1424, 1425
 Polygamy, 2: 601
 Polyneuritis, 4: 1366
 Ponderal index, 2: 359
Population Bulletin (U.N.), 6: 1912
 Population control, 5: 1531-42
 Population problems, 1: 43, 44, 162, 260-61; 2: 536; 3: 1051; 5: 1531-42; 6: 1912, 1967, 2068
 Pornography, 1: 46; 3: 759; 5: 1849
 Porphyria, 1: 228, 245
 Porteus Maze test, 5: 1609
 Portugal, 6: 1983
 Posthypnotic suggestion, 3: 801, 804, 805
 See also under Hypnosis
 Postpartum blues and depression, 1: 7, 23, 82, 354; 2: 463, 466; 3: 1039
Power and Personality (Lasswell), 5: 1526
 Practical nursing, 1: 272
 Pragmatism, 2: 745
 Precognition, 4: 1421, 1422-3, 1427
 Precollapse personality, 4: 1309
 Preconscious processes, 2: 506; 3: 810; 4: 1352; 6: 2000
 Predelinquency, 1: 66
 Premies. *See* Prematurity
 Prefrontal lobotomy. *See* Lobotomy
 Pregnancy, 1: 337-54; 2: 525; 3: 765, 767, 768; 4: 1182, 1360, 1379, 1446; 5: 1537; 6: 1868, 1880
 envy, 5: 1688
 fear of, 2: 644, 646, 647, 649, 650; 3: 1025, 1026
 See also Conception; Premarital pregnancy
Pregnancy, Birth and Abortion (Gebhard, Pomeroy, Martin, and Christenson), 1: 27
 Prejudice, 3: 832; 5: 1543-55, 1619; 6: 1931, 1935
 Premarital counseling and examination, 2: 660; 6: 1968
Premarital Intercourse and Interpersonal Relationships (Kirkendall), 2: 385
 Premarital intercourse and pregnancy, 1: 64; 2: 382, 384, 385, 386, 391-5, 604; 5: 1707; 6: 1873, 1966, 2067
 Prematurity (birth), 1: 9; 2: 527, 528, 531, 604; 4: 1192, 1270
 Premenstrual tension, 3: 1030
 Premonition. *See* Precognition
 Prenatal education and examinations, 1: 319; 4: 1192; 5: 1561
 Preschool children, 1: 316; 4: 1202; 5: 1690-1691; 5: 1695-6
 President's Committee on Juvenile Delinquency and Youth Crime, 3: 907
 President's Panel on Mental Retardation (1961), 4: 1202
 Prevention and preventive therapy, 1: 313, 319, 329; 2: 614, 637, 694; 3: 900, 901, 1095; 4: 1103, 1121, 1132, 1209, 1211, 1214, 1228, 1230, 1352; 5: 1556-66, 1856-7; 6: 2054, 2058
 Preventive medicine, 1: 142; 5: 1515
 Price Seizure Clinic. *See* Jerry Price Seizure Clinic
 Primal anxiety, 4: 1340
 Primal scene, 2: 653; 5: 1691-2
 Primary behavior disorder, 3: 898
 Primary process, 2: 504; 5: 1587-8, 1590, 1839; 6: 2003, 2004
 Primidone, 2: 570
Primitive Culture (Tylor), 6: 1897
 Primitive thinking, 4: 1434; 5: 1489
 Princeton University (N.J.), 3: 1080, 1081
 "Principles of Management of Psychosomatic Disorders" (Rosenbaum and Reiser), 5: 1712 n.
Principles of Psychology, The (James), 5: 1620
 Prisoners Aid Association, 2: 380
 Prison psychiatry and prisons, 1: 322; 2: 367-80, 604; 3: 749, 915, 916, 927, 928; 4: 1137
 Privacy, 4: 1170; 6: 2035, 2044
 Probation, 2: 376-7, 409; 3: 903, 904, 905
Problem of Anxiety, The (S. Freud), 6: 1977
 Problem families, 2: 596, 597, 606
 Professional personnel, 2: 607, 608, 611, 656; 4: 1118, 1142-3; 1169, 1209, 1220; 6: 2017, 2051, 2054, 2055, 2070
 See also Clergy; Mental health professionals; Nurses; Psychiatry; Psychoanalysis; Psychology; Social work
 Proficiency tests. *See* Achievement tests
 Progesterone, 3: 765, 1024, 1027
 Progressive education, 3: 939, 940
 Projection, 2: 461, 691; 3: 840, 956; 4: 1158-1159, 1164, 1263, 1412, 1417, 1418; 5: 1489, 1496, 1526, 1549; 6: 1919, 1978
 Projective techniques and tests, 2: 418, 540, 688, 694, 695; 3: 966, 1076; 5: 1506; 6: 1990
 Prolactin, 3: 768
 Promiscuity, 1: 61, 63; 2: 386, 654; 3: 758, 759; 5: 1708

- Propaganda**, 3: 996
Prophecy, 4: 1425, 1433
Prostate gland disorders, 1: 139
Prostitution, 3: 749, 758, 840; 4: 1279; 5: 1853, 1863
Protein metabolism and proteins, 1: 231; 4: 1191, 1356-9; 5: 1787
Protestant Association of Hospital Chaplains, 4: 1453
Protestant, Catholic, Jew (Heiberg), 5: 1748
Protestant church and Protestants, 1: 11; 2: 436, 447; 4: 1251, 1450, 1451; 5: 1578; 6: 1967, 1973
Pseudohermaphroditism, 5: 1850
Pseudolanguage, 1: 332
Pseudoneurotic schizophrenia, 5: 1788
Psi, 4: 1421-36
Psychestat theory, 4: 1360
Psychiatric Aspects of Juvenile Delinquency (W.H.O.), 4: 1200
Psychiatric checkups, 1: 141; 2: 610
Psychiatric classification, 4: 1335
Psychiatric drugs. *See* Drug therapy; Pharmacotherapy; Psychopharmacology; Sedative drugs; Tranquilizing drugs; under name of drug
Psychiatric evaluation study, 1: 308
Psychiatric Foundation, 3: 1099; 4: 1286, 1287
Psychiatric hospitals, 5: 1576; 6: 1900, 1943, 1994
 private, 4: 1134
 See also Mental hospitals
Psychiatric nursing, 1: 258, 260, 261, 262, 269-72
Psychiatric social work; 1: 268, 315, 316; 2: 360; 3: 1095, 1096; 4: 1117, 1118; 5: 1739
Psychiatric Social Work Section (N.A.S.W.), 3: 1094
Psychiatry, 1: 258, 261, 262, 265, 324, 326, 333; 2: 367-80, 410, 413, 514, 520-21, 533, 569, 588, 622, 659, 685, 712; 3: 775, 813, 847, 850, 859, 891, 898, 908-29, 945, 959, 961, 963, 980, 982, 983, 1034, 1039-40, 1067, 1078, 1080-85, 1089, 1090, 1092, 1095-7; 4: 1105-7, 1111, 1118, 1138, 1197, 1199, 1215, 1233, 1243, 1293, 1306, 1308, 1310, 1335, 1348, 1429, 1449; 5: 1550, 1555, 1556-1558, 1565, 1567-85, 1617, 1622-3, 1730, 1738-9, 1756-8, 1760, 1767, 1771, 1823-4, 1847, 1853; 6: 1879, 1943, 2012, 2036, 2052, 2054
 and religion, 5: 1748-59
 history of, 2: 737-46; 3: 1102
 See also Child psychiatry; Dynamic psychiatry
Psychiatry in a Troubled World (W. C. Menninger), 4: 1224
Psychical research, 4: 1421, 1424, 1435
 See also American Society for Psychical Research; Society of Psychical Research (British)
Psychic determinism and overdeterminism, 2: 636, 639; 5: 1587
Psychic energy, 3: 1005
Psychoanalysis, 1: 123, 176, 201, 258, 279-281, 282, 292, 295, 313, 314, 331, 333, 339; 2: 360, 417-19, 437, 439, 471, 501, 504, 509, 516-17, 520, 533, 543, 544, 587, 591, 597, 599, 621, 631, 632-42, 657, 659, 706, 711; 3: 741-2, 744, 745, 750-51, 759, 792, 797, 803, 818, 823-4, 826, 845, 847, 856, 858, 865, 868, 999, 1015, 1086; 4: 1157, 1160, 1164, 1215, 1248, 1310, 1344, 1402-5, 1431, 1449, 1483; 5: 1488, 1491-3, 1568-70, 1572, 1574, 1575, 1586-1604, 1621, 1667, 1682, 1729, 1730, 1749, 1755-6, 1760, 1786, 1854; 6: 1879, 1900, 1911, 1926, 1987, 2002, 2003, 2004, 2054, 2055
 See also in Name Index, Freud, Sigmund
Psychobiology, 3: 745; 5: 1574, 1576, 1734, 1786
Psychodiagnostic testing and tests, 1: 311; 2: 691; 3: 891, 933, 1088; 4: 1181; 5: 1530, 1605, 1608-17, 1628; 6: 2005
Psychodrama, 2: 544, 709, 710, 712; 3: 742, 743; 4: 1344; 5: 1515
Psychodynamic Significance of Beliefs Regarding the Cause of Illness (Bard and Dyk), 5: 1495
Psychogenetics, 1: 105; 4: 1387, 1391, 1474
Psychokinesis, 4: 1421, 1424, 1434, 1435, 1436
Psychological Corporation (N.Y.C.), 3: 944
Psychological health and sickness, 4: 1346-1349; 5: 1498
Psychological Stress (Janis), 5: 1496
Psychological testing and tests, 2: 468; 3: 873, 876, 880, 998, 1088; 4: 1299, 1490; 5: 1605-7, 1608; 6: 2031, 2032
 See also under name of test
Psychology, 1: 223, 258, 261-2, 265, 277, 287, 326; 2: 417, 547, 585, 623, 637, 663, 668, 682, 687, 694, 698, 712; 3: 859, 882, 884-6, 891, 898, 914, 929, 932, 945, 949, 979, 988, 1002, 1067, 1080, 1084, 1088; 4: 1106, 1197, 1198, 1229, 1233, 1245, 1257, 1259, 1260, 1262, 1293, 1421, 1428, 1437, 1449, 1467, 1472; 5: 1556, 1568-9, 1571, 1574, 1576, 1584, 1588, 1590, 1595, 1605-9, 1618-33, 1718, 1760, 1763-4, 1847; 6: 1900, 1909, 1910, 1925, 2054
 See also Social psychology

- Psychology of Politics, The* (Eysenck), 5: 1524
- Psychometry*, 5: 1619
- Psychoneuroses and psychoneurotic disorders*, 2: 364; 3: 758, 898, 1040, 1044-1045, 1049, 1059, 1060, 1062, 1063, 1064; 4: 1106, 1307, 1337, 1469, 1480-1481; 5: 1594; 6: 1909, 1912, 2076
- See also Neuroses*
- Psychopathic personality and psychopaths*, 1: 283; 3: 764, 855, 912; 4: 1233, 1265, 1337, 1338-9, 1349; 5: 1480-81, 1634-1653, 1819; 6: 1903, 1909, 1910
- See also Sexual psychopaths*
- Psychopathology and Politics* (Lasswell), 5: 1524
- Psychopathology of everyday life*, 1: 333; 5: 1591
- Psychopathology of Everyday Life* (S. Freud), 1: 333
- Psychopharmacology*, 1: 228; 3: 962; 4: 1343; 5: 1654-63
- Psychophysiologic disorders*, 3: 1041-5, 1048-9; 5: 1620
- Psychophysiologic Medicine* (Ziskind), 5: 1570
- Psychosexual development and psychosexuality*, 1: 291, 294; 2: 649; 3: 741, 820; 4: 1410, 1416, 1438; 5: 1578, 1588-90, 1678-1709; 6: 1966
- See also Psychosexual differentiation*
- Psychosexual differentiation*, 5: 1679-82, 1686-90
- Psychosis and Civilization* (Goldhamer and Marshall), 6: 1908
- Psychosis and psychotic reactions*, 2: 456, 462, 463-4, 470, 472, 501, 518, 519, 555, 556, 637, 692, 708; 3: 801, 816, 852, 857, 858, 912, 958, 1005, 1013, 1017, 1021, 1032, 1038, 1041, 1043-4, 1046, 1048, 1100; 4: 1227, 1295, 1333, 1335-6, 1338, 1340, 1366, 1410, 1469, 1480, 1481; 5: 1560, 1588, 1594, 1664-1677; 6: 1919, 1981, 2050
- See also Schizophrenia*
- Psychosocial Problems of College Men* (Wedge), 3: 1089
- Psychosomatic illness*; 1: 126, 131, 316, 2: 456, 528, 546, 554-5, 631, 641, 650, 654, 705, 726, 732; 3: 982, 1030, 1045-6, 1081; 4: 1264, 1295, 1307, 1333, 1337, 1342, 1402-3, 1450; 5: 1498, 1571, 1574, 1616, 1710-21, 1730, 1763; 6: 1909, 1912, 1980
- Psychosurgery*, 4: 1401; 5: 1722-7
- See also Lobotomy; Neurosurgery*
- Psychotherapy*, 1: 123; 2: 544, 586, 587-91, 621, 631; 3: 737, 741, 743, 797, 814-5, 826, 831, 847, 856, 880, 952, 962, 963, 1022, 1031, 1066, 1085, 1086; 4: 1111, 1164, 1195, 1209, 1210, 1211, 1219, 1265, 1339, 1343-4, 1383, 1419, 1420, 1431, 1464, 1466, 1482; 5: 1498, 1499, 1554, 1572, 1579, 1584, 1595, 1601, 1728-36, 1772; 6: 1902, 1905, 1939, 1990, 2076, 2077
- Psychotomimetics*, 5: 1654, 1656-7
- Puberty*, 2: 525; 3: 769, 1011, 1024; 5: 1589, 1679, 1702-5
- Public Affairs Committee (N.Y.C.)*, 4: 1332
- Public health*, 5: 1558, 1559
- nursing*, 3: 905; 6: 2055
- service. See U.S. Public Health Service*
- Puerto Rico*, 4: 1278; 5: 1528, 1539, 1546
- Punishment*, 1: 294; 2: 367, 370, 413; 4: 1259, 1408; 5: 1496
- Pupillary reflex*, 1: 289
- Pyknic temperament*, 2: 363; 3: 959
- Pyromania*, 5: 1860
- Pyrophobia*, 4: 1485
- Quakers*, 1: 161
- "Queers,"* 3: 747
- Quest for Mental Health, The* (A. Deutsch), 2: 480
- "Quiet desperation,"* 4: 1340
- Rabies*, 1: 243
- Race. See under name of race*
- Racial memory and racial unconscious*, 3: 1002; 4: 1340
- Racketeering and rackets*, 2: 403; 3: 897, 899
- Radiation and radioactivity*, 2: 733-4; 4: 1366
- Rage*, 3: 550, 626; 4: 1334
- "Railroading,"* 3: 780, 782
- Rape*, 1: 12; 2: 406; 5: 1849
- Rationalization*, 4: 1156, 1162, 1263; 5: 1485, 1547, 1554; 6: 1919, 1978
- Rauwolfia*, 3: 745; 5: 1655, 1659; 6: 2053
- "Reaching out" programs*, 3: 906
- Reaction formation*, 3: 808; 4: 1158, 1164, 1480
- Reading and reading disturbances*, 1: 30; 3: 930-49, 897; 4: 1198-9; 5: 1612
- Reality principle and testing*, 2: 517, 518; 3: 1074; 4: 1155, 1410, 1411, 1463, 1487; 5: 1517, 1521, 1590-91, 1749; 6: 2047, 2072, 2073, 2076
- Rebellion*, 1: 54, 56, 57, 59, 60, 80, 110; 2: 455; 3: 793, 932; 4: 1216, 1441; 6: 1872, 1905, 2065, 2071
- Rebel Without a Cause* (Lindner), 5: 1525

- Recall.** *See* Memory
Recovery, Inc., 2: 709; 3: 743
Recreation and recreational therapy, 4: 1168, 1219; 5: 1511-22; 6: 2077
Red Cross. *See* American Red Cross
Reducers (pain), 4: 1392, 1393
Referrals for psychiatric treatment, 1: 124; 4: 1119, 1219, 1250, 1254; 5: 1627, 1825
"Regional Differences in Anti-Negro Prejudice" (Pettigrew), 5: 1553
Regression, 3: 787, 807-8, 809, 810, 830, 1044; 4: 1161, 1164, 1280; 5: 1498, 1667
Rehabilitation, 1: 143, 259; 2: 367, 369, 373, 378, 379, 412; 3: 776, 903, 916, 917, 928; 4: 1109, 1114, 1121, 1127, 1144, 1178-9, 1202, 1305, 1329; 5: 1494, 1498, 1503, 1506, 1509, 1737-47; 6: 1929, 1943, 1993, 2079
Rejection, 1: 79, 89, 287, 295, 297; 2: 490, 491, 598; 3: 761, 952, 960, 977, 1083; 4: 1250, 1368, 1441, 1443; 5: 1545; 6: 2029
Relationship therapy. *See* Therapeutic community
Relaxation. *See* Recreation
Religion, 1: 11, 12, 19, 69, 86, 137, 176; 2: 434-5, 583, 627, 638, 706; 3: 829, 979, 980, 984, 991, 996; 4: 1250, 1251, 1252-1253, 1450, 1472; 5: 1528, 1531-3, 1534, 1538, 1545, 1573, 1575, 1578, 1846; 6: 1874, 1976, 1990, 2005
 and psychiatry, 5: 1748-59
Religious Education Association, 5: 1579
Remarriage, 1: 137, 138; 2: 491-2; 6: 2023
Remarriage (J. Bernard), 2: 487
Remedial reading, 3: 947-8
Renaissance medicine, 3: 740
Repetition compulsion, 1: 168-9; 5: 1590-91
Report of the Inter-Departmental Committee on Abortion (British Ministry of Health), 1: 27
Repression, 1: 131, 215, 278, 291, 332, 333; 2: 502, 503, 606, 634; 3: 818, 819, 820, 821, 824, 854, 994, 1001, 1005; 4: 1157, 1158, 1159, 1162, 1164, 1263; 4: 1339, 1480, 1483; 5: 1486, 1487; 6: 1977-8, 2000, 2002, 2003
Republic (Plato), 4: 1337
Research and mental health, 5: 1760-68
Research Career Awards (NIMH), 4: 1298, 1299
Research grants (NIMH), 4: 1297
Research Utilization Branch (NIMH), 4: 1300
Reserpine, 1: 229, 245; 5: 1655, 1659
Residential treatment. *See* Children, residential treatment
Resistance, 3: 850; 4: 1157, 1164; 5: 1596, 1598; 6: 2002
Rest homes, 4: 1134-5
Restitution. *See* Atonement
Restraints, 4: 1171-2
Retardation. *See* Mental retardation
Retarded children. *See* Association for Retarded Children; Children, retarded
Retirement (from work), 1: 121, 127, 128, 135, 139, 142, 154, 156, 157, 163, 165, 166; 2: 398, 463; 3: 832; 4: 1206; 6: 2029, 2036
 hotels and states, 1: 161, 174
"Review of Existential Psychology and Psychiatry" (Van Kaam), 2: 595
Revolutionaries, 5: 1525; 6: 1989
Rewards, 1: 294, 299, 370; 3: 930, 931, 934, 935; 4: 1259, 1260
Rheumatism, 3: 1017; 5: 1494
Rheumatoid arthritis, 5: 1712
Rh factor, 4: 1192
Rhinencephalon, 5: 1787
Rhinitis, 2: 722
Rice University (Texas), 2: 434
Rickets, 2: 537; 4: 1365
Rickettsial diseases, 1: 243
"Right and wrong test," 1: 410; 3: 910; 4: 1334, 1347
Rigidity, 1: 294; 3: 797, 1083; 4: 1205, 1348, 1349, 1352; 5: 1526, 1552; 6: 1878
Rites de passage, 6: 1901, 1902
Rituals, 1: 321; 2: 418, 422, 437, 440, 635; 3: 991; 4: 1158; 6: 1922, 1923
"Rituals of rebellion," 6: 1905
Riverside Hospital (N.Y.C.), 4: 1283
Rockefeller Foundation, 2: 447; 5: 1765
Rockefeller Memorial. *See* Laura Spelman Rockefeller Memorial
Rocky Mountain spotted fever, 1: 243
Role and roles, 2: 710; 5: 1515
 See also Feminine role; Gender role; Male role; Sex roles
Role of Insight in Psychotherapy, The (Reid and Finesinger), 3: 855
Romantic love, 2: 383, 387, 391, 551; 3: 931; 5: 1842; 6: 1872, 1882, 2067, 2074
Rome (ancient), 2: 679, 684; 4: 1187, 1345; 5: 1523
Rorschach test, 1: 346; 2: 418, 421, 465, 540; 3: 890; 4: 1431, 1477; 5: 1609, 1614, 1617; 6: 2005
Royal Society of London, 2: 570
Running away, 1: 304; 4: 1158
Russell Sage Foundation, 5: 1765
Russia, 1: 254; 4: 1398; 5: 1470, 1471, 1606, 1621, 1729; 6: 2059
 See U.S.S.R.; Soviet Union
Russian Red Cross, 4: 1213

- Russian roulette, 6: 1988
 Russo-Japanese War, 4: 1213
- Sadism and sadomasochism, 3: 758; 4: 1404–1405; 5: 1849, 1851
- St. Elizabeths Hospital (Washington, D.C.), 4: 1296
- Saint Joseph's College (Phila.), 4: 1428
- St. Louis Labor Health Institute, 4: 1150, 1152
- St. Vitus' dance, 5: 1669
- Salmon (Thomas W.), Psychiatrist (Bond)*, 3: 1101
- Salpingectomy, 6: 1970
- Salvation Army, 2: 379; 6: 2080
- Sample surveys, 6: 1928–9, 1930, 1931
- San Diego (Calif.) Dept. of Health Education, 5: 1845, 1846
- Sanitariums, 4: 1134–5
- Satanism, 3: 803
- Satire, 2: 398; 3: 787, 789
- Scales. *See* Intelligence testing
- Scandinavian countries, 1: 16, 22, 28; 2: 565, 566; 3: 887, 1052; 5: 1571, 1625
See also under name of country
- Scapegoating, 2: 606, 615; 3: 995; 4: 1187, 1377; 5: 1526
- Scarlet fever, 4: 1183, 1192
- Schistosomiasis, 1: 243
- Schizophrenia, 1: 97, 123, 229–34, 317–18, 324, 345, 346; 2: 361, 439, 461, 463, 508, 519, 542, 555, 562–3, 565, 598, 600, 640, 731; 3: 790, 808, 815, 821, 825, 830, 831, 852, 857, 858, 879, 898, 959–60, 995, 1044, 1046, 1048, 1055–7, 1060, 1063, 1064, 1082; 4: 1120, 1159, 1164, 1195, 1215, 1218, 1220, 1230, 1235, 1271, 1309, 1317, 1337, 1338, 1343, 1355, 1408, 1410, 1411, 1419, 1442–4, 1447, 1468, 1481, 1483; 5: 1523, 1574, 1658, 1669, 1724, 1782–98; 6: 1820, 1915–16, 1918, 1930, 2050, 2076, 2077
- Schizothymia, 4: 1469
- School and schools,
 and mental health services, 5: 1799–1828
 counseling, 1: 58, 59; 5: 1577, 1815, 1819, 1824
 discipline, 5: 1811–12
 high school, 5: 1817
 dropouts, 3: 907, 939; 5: 1818–19
 phobias, 3: 899; 5: 1491–2, 1802–3
 psychologists, 2: 669; 3: 891; 5: 1823
See also Education
- Schreber case, 5: 1670
- Science and Arts Camps, Inc., 2: 675
- Science and Sanity (Korzybski)*, 1: 331
- Scopolamine, 2: 745
- Scotland, 6: 1983, 1996
- Scots Charitable Society of Boston, 6: 1942
- Screening, 4: 1222, 1229; 6: 2012
- Scrupulosity, 4: 1250, 1451
- Scurvy, 4: 1365; 5: 1558
- "Secondary gains" (from illness), 2: 613, 618; 3: 825, 826; 4: 1381, 1402
- Secondary process, 2: 506; 5: 1588, 1590, 1839; 6: 2003
- "Second childhood," 1: 167
- Second Conference on Group Processes, 5: 1511
- Second Opium War, 4: 1277
- Secretiveness, 1: 41; 3: 770; 4: 1413
- Sedative drugs, 1: 135, 216; 2: 469; 3: 745, 821, 1031; 4: 1276; 5: 1654; 6: 1894
- Seizure and seizures, 2: 569, 571–2, 576
 clinics, 2: 580
- Selected Studies in Marriage and Divorce (Winch and McGinnis)*, 1: 137
- "Selective inattention," 3: 854
- Selective Service statistics, 3: 1052; 4: 1287, 1293
- Self, 4: 1472; 5: 1618, 1621
See also Ego
- Self-accusation, 2: 422; 3: 959, 960, 963; 5: 1496; 6: 2065
- Self-confidence and self-esteem; 2: 527; 4: 1259, 1264, 1447; 5: 1486, 1497, 1504; 6: 1920, 1975, 2014
- Self-control, 4: 1480; 5: 1529
See also Self-discipline
- Self-deception, 4: 1156
- "Self-demand" feeding, 1: 293–4
- Self-destruction. *See* Suicide
- Self-discipline, 1: 111, 292; 2: 556, 666; 6: 2046, 2065, 2067
- Self-dramatization, 5: 1524
- Self-expression, 2: 680, 682, 691
- Self-hypnosis, 3: 801–2, 803, 812, 816
- Self-image, 3: 1068–9, 1073, 1074, 1075, 1079; 6: 1917, 1918
- Self in Pilgrimage, The (Loomis, Jr.)*, 5: 1578
- Selfishness, 2: 952
- Self-knowledge, 3: 831, 850, 851, 853, 1068; 4: 1483; 5: 1614
- Self-love, 1: 155; 2: 636; 3: 957
See also Narcissism
- Self-overvaluation, 4: 1470, 1480
- Self-pity, 6: 2005
- Self-preservation, 1: 145, 147; 2: 517; 5: 1590
- Self-punishment, 2: 717; 4: 1157, 1250, 1257, 1403
- Self-realization, 3: 1069, 1074, 1076; 4: 1340; 5: 1749
- Self-respect, 6: 2043, 2047, 2074
- Self-sadism, 5: 1849
- Self-theory (personality), 5: 1621

- Semantics**, 1: 331
- Senate Subcommittee on Constitutional Rights of the Mentally Ill**, 2: 477
- Senile brain disease**, 2: 461, 463, 465, 472; 3: 1042, 1056, 1057, 1064; 5: 1830, 1831, 1832
- Senile dementia**, 5: 1829, 1830, 1835-6
See also Senile psychoses
- Senile psychoses**, 1: 143, 159, 168, 228; 2: 562; 3: 934, 1039, 1059, 1063; 4: 1120, 1366, 1408, 1415; 5: 1829-36
- Senior Citizens of America**, 6: 2079
- Senior citizens' organizations**, 1: 162
- Seniority principle (in industry)**, 6: 2038
- Sense of humor**, 3: 788-9, 796-7
- Sense organs**. *See* Perception
- Sensory deprivation and sensory isolation**, 1: 38, 299, 306, 322; 2: 370, 424; 3: 991; 4: 1388, 1463; 5: 1763, 1837-41; 6: 1979
- Separation anxiety**, 1: 78, 129, 137, 301, 304; 2: 627, 653; 4: 1377
- Separation (marital)**, 2: 483, 484, 546
- Serotonin**, 1: 231, 232
- Sex and sexual**, 1: 39, 46, 126, 136, 280, 337; 2: 384, 631, 644, 645, 651, 652, 654, 655, 657; 5: 1533; 6: 2072
 and love, 2: 382; 3: 952-3, 954, 972
 and marriage, 6: 1867-85
 attitudes, 5: 1843-5
 characteristics, 3: 1001, 1024
See also Female characteristics; Male characteristics
 compatibility, 6: 1872
 continence, 5: 1531, 1534, 1536, 1537
 curiosity, 1: 304, 305
 cycle, 3: 1024-31; 6: 1963
See also Menstrual cycle
 desire and drive, 1: 61, 136-7, 155, 164; 2: 371, 550, 551, 639, 653, 655, 730; 3: 767, 792, 836, 840, 1018, 1019, 1020, 1027; 4: 1258; 5: 1679, 1703; 6: 1879-1880, 1963, 1965, 2067
 deviations, 1: 62; 2: 405-6, 542; 3: 750, 751, 757, 758, 762, 764, 791, 837, 839, 1046, 1049; 4: 1341; 5: 1697, 1730, 1848-57
See also Homosexuality; Perversions
 education, 1: 28, 46, 61, 319; 2: 653, 657, 660; 3: 841, 844-5, 848; 5: 1692-5, 1706, 1842-7; 6: 2071
 experimentation, 1: 56, 62, 63; 2: 384; 5: 1690, 1850
 hormones, 2: 550, 551, 732; 5: 1705-1707
 psychopaths and the law, 5: 1858-66
 roles, 1: 294-5; 2: 491, 645
See also Feminine role; Male role
- Sex Attitudes in the Home** (Eckert), 3: 969
- Sex Habits of American Men** (A. Deutsch, ed.), 3: 748
- Sex Life in Marriage** (Butterfield), 3: 968
- Sexual Behavior in the Human Female** (Kinsey), 3: 748
- Sexual Behavior in the Human Male** (Kinsey), 3: 748
- Sexual Harmony in Marriage** (Butterfield), 3: 968
- Sexuality, childhood**. *See* Childhood sexuality
- Shame**, 1: 292; 2: 547; 4: 1246, 1249
- Shame of the States, The** (A. Deutsch), 2: 477, 478; 3: 776, 1098
- Shell shock**, 3: 741; 4: 1106, 1214; 5: 1576
- Sheltered workshops**, 4: 1115, 1130, 1135, 1202; 5: 1744
- Shock therapy**, 1: 5, 178, 229; 2: 439, 470-72, 520, 544; 3: 762, 962, 1008; 4: 1111, 1173, 1210, 1343, 1401, 1419, 1420, 1483; 5: 1565, 1569, 1574, 1595, 1722, 1796-7, 1855; 6: 1923, 2052, 2053, 2077
- Shoplifting**, 2: 406
- Shy Guy** (film), 5: 1845
- Shyness**. *See* Withdrawal
- Siamese twins**, 4: 1268
- Sibling rivalry and siblings**, 1: 50-51, 298, 305; 2: 597, 601, 673; 4: 1268, 1446; 6: 2064
- "Sick" mind and personality**, 4: 1234
- "Sidedness,"** 3: 683
- Sight**. *See* Eye and eyesight
- Sigmund Freud and the Jewish Mystical Tradition** (Bakan), 5: 1758
- Signal function (superego)**, 4: 1249
- Sin**, 5: 1752-3
- Sinai Hospital** (Baltimore, Md.), 1: 11
- Single Parents, Inc.**, 2: 495
- Skin**, 3: 767; 4: 1465
- Skinner box**. *See* Animal experiments
- Sleep and sleep deprivation**, 1: 254, 303, 304, 306; 2: 500; 3: 864, 1009; 4: 1231; 5: 1840; 6: 1886-95
- Sleeping pills**, 6: 1894
- Sleeping sickness**, 1: 243; 6: 1892
- "Sleep teaching,"** 6: 1892
- Sleep therapy**, 6: 1891
- Sleepwalking**. *See* Somnambulism
- Slips of the tongue**, 2: 635; 4: 1263; 5: 1586
See also Psychopathology of everyday life
- Slow learners**, 2: 941
- Smallpox**, 1: 289; 5: 1558
- Smith College** (Mass.), 3: 1095
- Snake Pit, The** (film) and "snake pits" 3: 776, 1098
- Social agencies**. *See* Agencies

- "Social and Emotional Development of Students in College and University" (Farnsworth), 3: 1089
- Social anthropology, 4: 1335; 6: 1896-1906, 2006
- Social biology, 2: 523
- Social casework, 6: 1945, 1947-9
- Social change and mental health, 6: 1902, 1907-14
- Social crippling, 6: 1943
- Social crises. *See* under Crises
- Social disorganization, 6: 1921-2
- Social environment, 3: 742, 832; 4: 1235, 1474; 5: 1580
- Social factors in mental illness, 6: 1915-24
- Social isolation 6: 1920-21
- Social mobility. *See* Mobility
- Social psychology, 3: 880, 993; 5: 1764; 6: 1925-32
- Social Science Research Council, 5: 1506
- Social sciences, 5: 1763-4; 6: 1899-1900, 1927, 2076
- Social Security Administration, 1: 164; 4: 1153, 1305; 6: 2024
- Social status. *See* Status
- Social work, 1: 258, 260-63, 267 8; 2: 622; 3: 898, 979, 986, 988, 1085, 1096, 1097; 4: 1105, 1107, 1176, 1179, 1197, 1200, 1209; 5: 1556, 1571, 1630, 1738, 1822-1823; 6: 1941-51, 2037, 2056, 2058
- Social Work Research Group, 6: 1947
- Society of Applied Anthropology, 6: 1899
- Society of Hospitalers, 3: 739
- Society for Psychical Research (American), 4: 1425, 1426, 1427
- Society of Psychical Research (British), 2: 437
- Society for the Scientific Study of Religion, 5: 1579
- Socioeconomic factors, 1: 134, 135; 2: 565-6, 725; 3: 873, 1058-62; 5: 1708; 6: 1910, 1915-24, 1930, 1931, 1933-40, 1953
- Sociology, 1: 287; 2: 418, 533, 546, 638; 3: 891, 929, 988; 4: 1251, 1257, 1278, 1340, 1354, 1437; 5: 1569, 1574, 1584, 1586, 1618, 1694, 1760, 1764, 1853; 6: 1900, 1925, 1928, 2005, 2049
- Sociopath, 3: 912, 1049; 4: 1338, 1480, 1481, 1482; 5: 1634-53; 6: 1909
- Sodium Amytal, 4: 1265, 1483; 5: 1839; 6: 2005
- Sodium Pentothal, 4: 1265, 1483; 5: 1839
- Somatonia and somatotypes, 2: 356, 359-60, 361, 419; 4: 1468, 1469, 1474
- See also* Body build
- Somatotropin. *See* Growth hormone
- Some *Special Problems of Children—Aged* 2-5 (N.A.M.H.), 4: 1290
- Somesthetic sense, 5: 1682
- Somnambulism, 2: 551; 3: 803, 819, 1050; 4: 1164; 6: 1892
- "Source trait," 4: 1476
- South Africa, 2: 447, 574; 6: 2051
- South America, 2: 574; 5: 1666; 6: 2053
- See also* under name of country
- Southbury State Training School (Conn.), 4: 1182
- South Dakota Medical Association, 6: 1973
- Soviet Union, 4: 1428, 1448, 1484; 5: 1666, 1722; 6: 1895, 2052
- See also* Russia
- Space exploration, 5: 1841
- Spain, 1: 30; 6: 1888, 1983
- Spanish-American War, 4: 1213
- Special classes and special schools, 4: 1190, 1198, 1201, 1291, 1329; 5: 1577, 1825-1828; 6: 2053
- Spectator sports, 5: 1513
- Speech and speech disorders, 1: 240; 2: 691; 3: 1050; 4: 1181, 1196, 1342; 5: 1772; 6: 1952-61
- Spermicides, 5: 1535-6
- Spies, 5: 1529
- Spinal deformities, 2: 360
- Spinal tap, 4: 1328, 1329
- Spiritualism, 4: 1425
- Spontaneity, 3: 710, 711, 743
- S.P.R. *See* Society for Psychical Research
- S.P.R.'s *Journal and Proceedings*, 4: 1426
- Sputnik I*, 4: 1484
- Stage fright, 3: 1007
- Stammering. *See* Stuttering
- Standard Motors rioting, 6: 1910
- Standard Nomenclature of Mental Disorders, 3: 1047 n.; 4: 1338
- See also* Nomenclature
- Standards for Adoption Service (Child Welfare League of Am.), 1: 86, 98
- Stanford-Binet scale and tests, 3: 668, 693, 884, 885, 890, 933; 5: 1608
- Stanford University (Calif.), 3: 885
- "Starvation experiment," 2: 359
- State Boards of Charities and Corrections, 6: 1942
- State Charities Aid Association (N.Y.), 3: 1096; 6: 1944
- State Departments of Corrections, 4: 1131
- State Departments of Mental Hygiene, 4: 1131, 1134
- State Departments of Public Health, 3: 775
- State Departments of Public Welfare, 1: 106, 176
- State Departments of Social Welfare, 1: 70, 85; 4: 1141
- State Education Departments, 4: 1203

- State Employment Services, 1: 223; 6: 2022
 State hospitals, 4: 1128-9
 See also Mental hospitals
 State medical societies, 4: 1331
 State Mental Health Associations, 4: 1291
 State mental health budgets, 2: 122
 "Statement of Policy of A.P.A. on Hypnosis," 3: 813
 State schools and training schools, 4: 1202
 See also under name of school
Statistical Abstract of the U.S. (1959), 6: 1966
Statistical Manual for the use of Hospitals for Mental Diseases, 3: 1040
 Statistics, 4: 1428; 5: 1531, 1532
 Status, 1: 116; 2: 566-7; 4: 1374; 6: 1933-40
 symbols, 6: 1935, 1938
 See also Socioeconomic factors
 Steady dating, 1: 55-6; 2: 381, 385, 387, 394; 5: 1707; 6: 1871
 Stereotypes, 5: 1548, 1554, 1689; 6: 1934, 1997, 2013, 2059, 2073
 Sterility, 1: 339; 2: 652; 3: 836, 838; 6: 1879, 1962-9
 Sterilization, 2: 577, 734; 3: 762; 4: 1189; 5: 1534-5; 6: 1870
 See also Eugenic sterilization
Sterilization for Human Betterment (Gosney and Popenoe), 6: 1971
 Steroids, 3: 765, 772
 S.T.H. *See* Growth hormone
 Stigmata Diaboli, 3: 739
 Stimulants, 4: 1276; 5: 1654, 1656; 6: 2055
 Stimulus-response concept, 4: 1471; 5: 1621
 "Stirling County Study" (Leighton), 6: 1901
 Stokes trial, 4: 1251
 Stomach ulcers. *See* Ulcers
 Stress and stresses, 1: 110, 130, 131; 3: 1046, 1069-70; 4: 1463, 1464; 5: 1491, 1495, 1499, 1500, 1534, 1540, 1571, 1763; 6: 1903, 1904, 1917-18, 1966, 1975-82, 2029, 2032, 2051
 Strokes, 1: 247; 4: 1327, 1328, 1329; 6: 1952
 "Structural" viewpoint, 1: 276; 5: 1621; 6: 2002, 2003
 Strychnine, 4: 1315, 1321
 Stubbornness, 2: 630
Student Mental Health (Funkenstein), 3: 1081
 Students and mental health, 1: 45; 2: 383; 3: 1082, 1088, 1089; 4: 1294; 5: 1501, 1611
 See also College mental health
Studies in Hysteria (Breuer and Freud), 2: 633
 Study methods, 2: 934-5
 Stupor therapy, 6: 1891
 Stuttering, 1: 304; 2: 689, 702; 6: 1952, 1954, 1955-9, 1961
 Subconscious, 6: 2001
 See also Unconscious
 Sublimation, 3: 864, 865; 4: 1156, 1162, 1263, 1340; 5: 1517
 Subliminal perceptions, 2: 504
 Submissiveness, 4: 1418
 Suburban living, 2: 423; 3: 896, 1057-8; 4: 1238-9; 6: 2068
 Sugar metabolism, 2: 575
 Suggestibility and suggestion, 2: 404, 544; 3: 741, 761, 800, 804, 816, 821, 822, 826, 920; 4: 1344, 1434; 5: 1838
 Suggestion boxes (industry), 6: 2030
 Suicide, 1: 23-4, 68, 135, 354; 2: 422, 446, 460, 465, 468, 469, 470, 534, 542, 704, 717, 726; 3: 780, 781, 808, 815, 961, 1082-3; 4: 1159, 1210, 1250, 1264, 1265, 1404; 5: 1500, 1657, 1821; 6: 1922, 1983-91
 Sumatra, 2: 681
 Sumerians, 4: 1336
 Superego, 1: 291; 2: 508-9, 518-19, 597, 655; 3: 742, 842, 900, 1069; 4: 1155, 1159, 1160, 1246, 1248, 1249, 1250; 5: 1487, 1490, 1491, 1495, 1592, 1688; 6: 2002, 2003
 Superstition, 2: 435; 3: 844, 1021, 1028
 Supportive therapy, 3: 1087; 4: 1482
 Suppression, 3: 994, 1005
 "Surface trait," 4: 1476
 Surgery, 2: 529, 531; 4: 1400, 1494-6, 1498, 1500
 Survey Research Center, 6: 2030
 Suspiciousness, 2: 461, 464, 601; 3: 1017; 4: 1409, 1418; 5: 1499, 1524, 1567, 1821
 Sweden, 1: 10; 2: 483; 3: 1549, 1571; 6: 1983, 1984, 2060
 "Swish," 3: 752, 753
 Switzerland, 1: 10, 30; 2: 640, 688, 696, 699; 3: 1081; 5: 1574, 1606, 1625, 1786; 6: 1983, 1984
 Symbolization and symbols, 2: 321, 326, 510, 511, 682, 684; 3: 741, 872, 996, 1002; 4: 1157, 1159, 1161, 1164, 1232, 1251, 1263, 1358, 1363, 1404, 1489; 5: 1588; 6: 1987, 1988, 2003, 2044
 Symptom formation, 4: 1162, 1163, 1164
 Synapses, 4: 1319-20
 Syphilis, 1: 227; 2: 563, 565; 4: 1173, 1192, 1481; 5: 1557; 6: 1870, 1908
 Syracuse (N.Y.) survey, 3: 1052
System of Medical Hypnosis, A (Meares), 3: 816
 Taboos, 3: 824; 4: 1252; 5: 1602
 Tammany Hall (N.Y.C.), 3: 798, 799

- Tapeworm. *See* Echinococcus
 Taraxcin, 1: 233; 5: 1787
 Tarzan (films), 5: 1695
 T.A.T. *See* Thematic Apperception Test
 Teacher Listen—the Children Speak (N.A.M.H.), 4: 1290
 Teen-ager. *See* Adolescence
 Telekinesis, 4: 1421, 1424
 Telepathy, 2: 438; 4: 1421–3, 1425, 1431, 1433, 1436
 Temperament, 2: 357, 360–64
 Temper tantrums, 1: 308; 2: 536; 3: 823
 "Temple sleep," 3: 803
 Temposil, 1: 195
 "Tender loving care," 1: 75
 Tennessee Valley Authority, 5: 1532
 Tension and tensions, 1: 110, 126–7, 135, 140, 151, 180, 181, 189, 296, 307; 5: 1616, 1655, 1658–9, 1715; 6: 2059–60
 headache, 2: 720–22
 Terminal illness, 2: 442, 705
 Testes and testosterone, 3: 765
 Testing and tests, 1: 297; 3: 852, 884–7
 See also under name and type of test
 Tetanus, 1: 289
 Texas Medical Practice Act, 3: 816
 Textbook of Pathology (Boyd), 1: 133
 Thailand, 6: 2052
 Thalidomide, 1: 19
 Thanatos, 2: 446; 3: 865; 4: 1339, 1591
 Theater of Spontaneity, 3: 710, 743
 Thematic Apperception Test, 2: 468, 540–541; 4: 1477; 5: 1609, 1617; 6: 2005
 See also Murray Thematic Apperception Test
 Theory of the Leisure Class (Veblen), 6: 1938
 Therapeutic Abortion: Medical, Psychiatric, Legal . . . Considerations (Rosen et al.), 1: 14, 27
 Therapeutic community, 3: 479, 620, 708, 743; 4: 1113, 1124, 1171, 1173; 5: 1730, 1732, 1742, 1764; 6: 1902, 1911, 1912, 1992–9
 Therapeutic Community, The (M. Jones), 6: 1912
 Therapeutic nursery schools, 1: 316
 Therapeutic social clubs, 2: 709, 710
 Therapeutic team, 1: 72–3, 78, 80–81, 201, 240, 265, 268, 314, 317; 4: 1449; 5: 1571, 1574, 1585, 1730, 1738, 1773–1, 6: 1944, 1995, 1998
 Therapist-patient relation, 2: 543, 590; 5: 1579, 1711; 6: 1993
 Thinking and thinking machines, 2: 552; 3: 1003; 4: 1326, 1355
 Third International Congress on Mental Health, 3: 1099; 6: 2061
 This Charming Couple (film), 5: 1845
 Thought transference, 4: 1421, 1432
 Three Essays on Sexuality (S. Freud), 2: 635
 Three Faces of Eve, The (Thigpen and Cleckley), 4: 1158; 6: 2001
 Three-generation households, 1: 172
 Thrombophlebitis, 1: 243
 Thymus gland, 3: 769
 Thyroid and thyroid-stimulating hormone, 1: 37, 228; 3: 767, 768, 772; 4: 1192, 1365
 Thyrotropin and thyroxin, 1: 192; 3: 768
 Timaeus (Plato), 4: 1336
 "Togetherness" (in marriage), 3: 967
 Toilet training, 1: 287, 291–2, 294, 296, 304, 305, 306; 3: 1000; 4: 1440; 5: 1490
 Toledo (O.) Family Court, 2: 486
 Tonsillectomy, 2: 653
 Topectomies, 5: 1725
 Tortura insomniacae, 6: 1888
 Toward a Successful Marriage (Peterson), 3: 968, 969
 Towards an Understanding of Juvenile Delinquency (Lander), 3: 895
 Toxemia in pregnancy, 1: 343; 4: 1192
 Toxic metabolic disorders, 1: 244–5
 Toxoplasmosis, 1: 243
 T p m o formulas, 4: 1478, 1479
 Trade unions, 6: 2042
 Traffic deaths. *See* Automobile accidents
 "Trainables," 4: 1182, 1201
 "Training in Medical Hypnosis" (A.M.A.), 3: 813
 Trance states, 4: 1425, 1434; 6: 1901, 2053
 See also Hypnosis
 Tranquilizing drugs, 1: 32, 35, 210, 216, 244, 259; 2: 479, 658; 3: 745, 777, 846–847, 962, 1100; 4: 1124, 1171–2, 1173, 1211, 1317, 1339, 1343, 1399–1400, 1419; 5: 1558, 1574, 1654–6, 1658, 1725, 1746, 1788; 6: 1894, 1923, 1930, 1933, 2052, 2055, 2076
 Transference, 2: 544; 3: 742, 824, 952; 4: 1156–7, 1160, 1337; 5: 1598, 1602, 1603, 1749; 6: 1990
 Transformation, 6: 2005
 Transient situational reactions, 3: 1041, 1046–7, 1050; 4: 1307, 1337, 1478; 6: 1945, 1976
 Transvestism, 3: 750, 758, 764; 5: 1697, 1849, 1853
 Trauma, 1: 235
 Treaty of Nanking (1842), 4: 1277
 Treaty of Tientsin (1858), 4: 1277
 Treponema pallidum, 4: 1481
 Trial marriage, 6: 1872–4
 Trichinosis, 1: 243
 Tridione and trimethadione, 2: 570, 578

- Triiodothyronine, 3: 768
Trouble with Cops, The (A. Deutsch), 3: 477
 Truancy, 1: 58, 66; 3: 899
 Trust, 2: 539, 542, 543, 550, 553, 593, 615; 4: 1209, 1254, 1397; 6: 2065
 Truth serum. *See* Sodium Amytal
 T.S.H. *See* Thyrotropin
 Tuberculosis, 1: 18, 19, 337; 4: 1035; 5: 1495, 1500, 1710; 6: 1962
 Tulane University (La.), 1: 233
 Tweed Ring, 3: 798, 799
 Twilight states, 2: 745
 Twins, 1: 267, 300; 2: 415-16, 567, 596, 697, 698, 725-7, 729, 731; 4: 1267, 1269
 See also Multiple births
 Typhoid delirium, 3: 1039
 Typhus, 1: 243

 Ulcerative colitis, 2: 555; 5: 1712
 Ulcers, 1: 134, 158, 324; 2: 555; 3: 1045; 4: 1334; 5: 1500, 1579, 1712, 1730
 "Ultimate concerns," 5: 1580
 Unconscious, 1: 138, 333; 2: 509-10, 516, 518, 544, 621, 624, 635-8, 640, 646, 653, 655, 683, 691; 3: 741, 754-5, 759, 834, 840-841, 925, 991, 1003, 1004, 1045, 1080, 1087; 4: 1154-65, 1231, 1233-4, 1245, 1247, 1251, 1262, 1263, 1403; 5: 1486, 1487, 1488, 1489, 1490, 1511, 1515, 1580, 1587-8, 1592, 1594, 1739, 1839; 6: 1869, 1878, 1880, 1881, 1882-3, 1963, 1966, 1977, 1987-90, 2000-2006, 2034, 2065
 Unconsciousness, 4: 1315
 Underachievement, 5: 1803-4
Understanding Grief (Jackson), 2: 441
 Undeveloped countries, 5: 1538, 1539
 See also under name of country
 Undoing, 4: 1161, 1164
 Unemployment, 1: 44; 6: 2040
 U.N.E.S.C.O., 6: 1905, 2061, 2062
 U.N.I.C.E.F., 6: 2062
 Union Theological Seminary (N.Y.C.), 2: 441
 United Epilepsy Association, 2: 579
 United Kingdom, 4: 1136; 5: 1625
 United Mine Workers' Welfare Fund, 4: 1119
 United Nations, 3: 1099; 4: 1204, 1369; 6: 2049, 2050, 2060, 2061
 U.S. Bureau of Census, 1: 34; 3: 1051, 1053, 1093; 6: 2013
 U.S. Bureau of Family Services, 6: 1946
 U.S. Bureau of Narcotics, 4: 1278
 U.S. Bureau of Public Assistance, 6: 1946
 U.S. Children's Bureau, 1: 71, 84, 319; 3: 893, 894, 895, 907; 4: 1127, 1130, 1186, 1191, 1202
 U.S. Civil Service Commission, 2: 574
 U.S. Department of Agriculture, 4: 1305, 1355-6
 U.S. Department of Defense, 4: 1305
 U.S. Department of Health, Education, and Welfare, 1: 122; 3: 907, 1098; 4: 1127, 1140, 1292, 1305, 1331; 5: 1503, 1506, 1509, 1746, 1747; 6: 1946
 U.S. Department of Labor, 3: 907; 4: 1331
 U.S. Food and Drug Administration, 4: 1361-2
 U.S. Military Academy, 3: 1081
 U.S. National Health Survey, 5: 1502, 1503, 1504
 U.S. Office of Education, 2: 676; 3: 907; 4: 1181, 1202
 U.S. Office of Vocational Rehabilitation, 4: 1127, 1202, 1305; 5: 1503, 1506, 1509
 U.S. Public Health Service, 3: 1052, 1093, 1098; 4: 1107, 1111, 1123, 1127, 1140, 1149, 1284, 1288, 1292, 1295, 1298, 1304, 1305, 1324, 1332; 6: 1944
 Demonstration Centers (Chicago and N.Y.C.), 4: 1283
 Hospital (Lexington, Ky.), 4: 1123, 1127, 1283, 1284, 1296; 5: 1578
 University of Berlin (Germany), 4: 1470
 University of California, 2: 427, 436, 444; 3: 1081
 University of Chicago, 2: 498; 3: 1081; 6: 1971
 University of Illinois, 3: 1085
 University of Iowa, 2: 687
 University of London (England), 4: 1432
 University of Manitoba (Canada), 4: 1434
 University of Michigan, 4: 1105; 6: 2028, 2030
 University of Minnesota, 2: 670; 3: 1081, 1085
 University of Nebraska, 3: 1081; 4: 1266
 University of Oklahoma, 5: 1837
 University of Pennsylvania, 3: 814; 4: 1106
 University of Wisconsin, 3: 1081, 1085
Unraveling Juvenile Delinquency (Glueck and Glueck), 2: 494; 3: 895
 "Unwellness," 3: 1012
 Urbanization, 1: 261; 2: 536, 645; 3: 838; 4: 1204, 1294; 5: 1508; 6: 1902, 1913, 1915, 1981, 2068
 Ur concepts and Ur-delusions, 4: 1340, 1345
 U.S.S.R., 2: 427, 601, 664, 700; 5: 1625
 See Russia

 Value conflicts and values, 1: 111, 277; 3: 900; 4: 1244-55, 1346; 5: 1497, 1544, 1545, 1548, 1560, 1732, 1750; 6: 1917, 1918, 1922, 1982, 2059, 2068, 2069, 2073

- Varieties of Delinquent Youth* (Sheldon, Hartl, and McDermott), 2: 357, 362
- Varieties of Human Physique* (Sheldon, Stevens, and Tucker), 1: 357
- Varieties of Temperament* (Sheldon and Stevens), 1: 357
- Vasectomy, 3: 762, 6: 1970
- Vassar College (N.Y.), 3: 1081
- Vegetative nervous system, 4: 1314
- Veneral disease, 6: 1964
- See also* Paresis; Syphilis
- Verbal skills, 2: 662, 677; 3: 880, 932
- See also* Language; Speech; Writing
- Veterans Administration and Veterans hospitals, 1: 223, 240; 3: 1100; 4: 1107, 1123, 1127-8, 1140, 1226, 1227-1228, 1305, 1331
- Victorianism, 2: 644, 645; 5: 1578, 1707
- Vineland (N.J.) Training School, 3: 884; 4: 1189, 1196
- Viral infections, 2: 581
- Virgin Islands, 2: 513; 5: 1561, 1668
- Virginity, 2: 391-2; 5: 1707
- Visceral, 2: 361; 4: 1469
- Visiting Nurse Association, 1: 176
- Vitamin deficiency and vitamins, 1: 227, 230; 4: 1357, 1362; 6: 1962
- Vocational counseling and testing, 1: 217-26, 259; 3: 904; 5: 1606, 1611, 1615, 1629; 6: 2022, 2027
- Vocational Rehabilitation office (N.Y.C.), 2: 580
- "Vodun" (Haiti), 3: 991
- Voice changes and set, 1: 42, 52, 327, 328
- Volta River Dam, 6: 2051
- Voluntary hospitals, 3: 777-9; 4: 1166, 1175, 1331
- Voodoo death, 2: 447
- Voyeurism, 2: 406; 5: 1697, 1848
- Wales, 6: 1983
- Walter F. Fernald State School (Mass.), 4: 1189
- War and wars, 2: 604; 3: 869, 1008, 1094; 4: 1213, 1214, 1216, 1222-5, 1308, 1312, 1343; 5: 1530, 1531, 1541; 6: 1917, 1918, 1934, 1966, 1977, 1981, 1985, 1989, 2007-12
- between the sexes, 3: 842; 6: 1882
- prisoners, 1: 253-7
- See also* World War I; World War II
- War, Politics and Insanity (Bluemel), 5: 1523
- Washburn College (Kansas), 3: 1081
- Washington (D.C.) Department of Corrections, 2: 372
- Washington University (St. Louis), 1: 233
- Wayne State University (Mich.), 1: 233; 6: 2028
- Weaning, 1: 294, 295; 4: 1440-41
- Wechsler Adult Intelligence Scale, 3: 885, 890, 933
- Wechsler-Bellevue Intelligence Scale, 2: 668, 693; 3: 885; 5: 1608
- for children, 3: 885, 933
- Weight consciousness, 1: 53; 2: 460, 464; 4: 1163, 1375-6
- Western Europe, 3: 887; 5: 1570
- See also* under name of country
- Western Pacific Health Service, 2: 447
- West Point (N.Y.), 3: 1081
- Wet dreams. *See* Nocturnal emissions
- What Medicine Can Do for Law* (Cardozo), 2: 411
- White noise, 4: 1396
- W.H.O. *See* World Health Organization
- Whooping cough, 1: 289; 4: 1183, 1192
- Widowhood, 6: 2013-26
- Witiko and windigo, 6: 1901, 1903
- Williams College (Mass.), 3: 1081
- Williamson County, Tenn., 3: 1052
- Wills (testaments), 3: 920
- W.I.S.C. *See* Wechsler-Bellevue Intelligence Scale for Children
- Wish fulfillment and wishes, 2: 504, 506, 507; 4: 1263; 5: 1512
- Wit. *See* Humor
- Witchcraft, 3: 737, 739, 803, 824, 995; 4: 1337, 1425, 1434; 6: 1904, 1922, 2033
- Withdrawal (psychic), 1: 52, 53, 67, 69, 155, 297, 304, 306, 307; 2: 647; 3: 770, 958, 995; 4: 1210, 1218, 1367; 5: 1561, 1784, 1821; 6: 1923, 1967, 2005, 2029, 2049
- Withdrawal syndrome (addiction), 4: 1400
- Wolffian ducts, 5: 1680
- Woman's Home Companion* (publication), 1: 20
- Women, 1: 47, 112; 2: 406, 537, 650-52; 3: 969-70, 975, 976, 982; 5: 1578; 6: 1868-1869, 1982, 2013, 2023, 2033, 2051, 2064, 2070-74
- See also* Widowhood
- Women's Two Roles* (A. Myrdal and Klein), 6: 2013
- Wonderful Story of How You Were Born, The* (Gruenberg), 5: 1845
- Work, 2: 535; 3: 1071, 1075; 4: 1163; 5: 1516, 1602; 6: 2022, 2024, 2027-48, 2054, 2066, 2069-70
- study plans, 5: 1819
- Work camps, 2: 367
- World Federation for Mental Health, 2: 423, 480; 3: 1099; 6: 1905, 1909, 2058, 2061, 2062
- World Federation of Neurology, 4: 1331

2228 Subject Index

- World Health Organization (U.N.), 2:** 574;
 3: 777, 1039, 1099; **4:** 1200, 1276; **6:**
 1914, 2049-62
 Mental Health Section, 6: 2058
World mental health, 6: 2049-62
World Mental Health Year (1961), 6: 1905
World population and world food supply,
 5: 1532-3, 1537, 1540
World War I, 3: 1094; **4:** 1214; **5:** 1576; **6:**
 2010
World War II, 3: 1094; **4:** 1214-5, 1219,
 1222, 1223-5, 1229, 1287, 1292, 1376,
 1443; **5:** 1839
Worms, 1: 243
 See also under name of worm
Worry, 2: 627; **3:** 837; **4:** 1389; **5:** 1495, 1567
- Writing, 2:** 681-2
 See also Graphology
- Yale University (Conn.), 3:** 770, 1081, 1089;
 4: 1471; **5:** 1496, 1551, 1572; **6:** 2042
Yorkville (N.Y.C.) survey, 3: 1052
Young adulthood, 1: 110; **5:** 1708; **6:** 2063-78
Youth, cult of, 1: 162, 164; **3:** 1017, 1018; **4:**
 1375-7
Yugoslavia, 6: 2056
Y.W.-Y.M.C.A., 1: 268; **2:** 379; **6:** 2022, 2024
Y.W.-Y.M.H.A., 6: 2022
- Zarontin, 2:** 570
Zen Buddhism, 4: 1345; **5:** 1758
Zoology, 3: 869
Zoophobia, 5: 1490